

Trial and Error: Legislating ADR for Medical Malpractice Reform

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Articles

TRIAL AND ERROR: LEGISLATING ADR FOR MEDICAL MALPRACTICE REFORM

LYDIA NUSSBAUM*

ABSTRACT

The U.S. healthcare system has a problem: hundreds of thousands of people die each year, and over a million are injured, by medical mistakes that could have been avoided. Furthermore, over ninety percent of these patients and their families never learn of the errors or receive redress. This problem persists, despite myriad reforms to the medical malpractice system, because of lawmakers' dominant focus on reducing providers' liability insurance costs. Reform objectives are beginning to change, however, and the vehicle for implementing these changes is alternative dispute resolution ("ADR"). Historically, legislatures deployed ADR to curb malpractice litigation and restrict patients' access to courts. Today, a new law in Oregon combines early disclosure and ADR to help injured patients get answers and compensation, and to improve medical safety. This Article examines Oregon's innovative ADR program and argues that, in contrast to earlier ADR reforms, the program constructs an entirely new alternative to the conventional tort system. This alternative shows promise and may succeed where other ADR reforms have failed; nevertheless, additional protections are critical to ensure fairness for patients, providers, and the public.

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INTRODUCTION

The U.S. medical liability system has had a problem for quite some time. Growing evidence indicates that a significant number of people in the United States die or suffer serious injury from mistakes in their medical treatment, yet neither they nor their families ever learn about the error or receive compensation. In the years since the Institute of Medicine (“IOM”) first named preventable patient deaths as a leading cause of death in its 1999 report, *To Err is Human*, more recent studies identify medical error as the third most common cause of death in the United States.¹ Anywhere from 200,000 to 400,000 patients die every year from medical errors that could be avoided.²

1. INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 1, 26 (Linda T. Kohn et al. eds., 2000) (estimating that between 44,000 and 98,000 people die each year from preventable medical errors in American hospitals, more than the numbers of people who die from “motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516)”; Martin A. Makary & Michael Daniel, *Medical Error—The Third Leading Cause of Death in the U.S.*, *BMJ* (May 3, 2016), <http://www.bmj.com/content/353/bmj.i2139> (referring to studies published after *To Err is Human* and indicating even higher numbers of fatalities due to medical errors).

2. John T. James, *A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care*, 9 *J. PATIENT SAFETY* 122, 125 (2013).

When it comes to nonfatal, preventable patient injuries, the incidence rates increase dramatically. The Office of Inspector General of the U.S. Department of Health and Human Services reports that, in one month alone, an estimated 130,000 Medicare beneficiaries sustained serious harm during hospitalization, nearly half of which might have been preventable.³

While preventable deaths and injuries from medical treatment demand attention, this Article addresses the problem of their aftermath. Specifically, that patients and providers lack a constructive legal process for addressing and responding to these incidents.⁴ The conventional tort system provides the traditional means for addressing patient injury through malpractice claims. But, for many reasons, this process fails to protect providers and patients.⁵ Providers tend to define medical error more narrowly than patients and rarely inform patients and their families when medical mistakes occur.⁶ In the absence of transparency, patients use malpractice claims to extract answers.⁷ The adversarial nature of lawsuits further drives a wedge between patients and providers and frustrates opportunities for candor and cooperation.⁸ The general lack of communication between providers and patients following an unanticipated, adverse outcome of medical treatment creates

3. DANIEL R. LEVINSON, DEP'T OF HEALTH & HUMAN SERVS., ADVERSE EVENTS IN HOSPITALS: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES 18, 22–24 (2010). In October 2008, forty-four percent of all serious harms (harms resulting in a prolonged hospital stay, permanent harm, necessitating life sustaining intervention, or contributing to the patient's death) and temporary harms were identified as “clearly” or “likely preventable.” *Id.* If this injury rate were sustained over twelve months, the annual number of injured patients would approximate 1.56 million Medicare beneficiaries severely injured by their medical care (and this is only Medicare beneficiaries, a subset of all patients in the United States).

4. For purposes of this Article, the term “providers” is used to describe all licensed professionals who provide health services to patients, such as doctors, nurses, physician's assistants, chiropractors, emergency medical technicians, physical therapists, pharmacists, and naturopaths.

5. *See infra* Part I.B.

6. *See generally* Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001 (2003); Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 HEALTH AFF. 73 (2003) (concluding from a study of 500 diverse hospitals that disclosure rates remain far below the estimated numbers of deaths and injuries, and many providers remain reluctant to disclose medical errors for fear of malpractice litigation).

7. *See generally* ROSEMARY GIBSON & JANARDAN PRASAD SINGH, WALL OF SILENCE: THE UNTOLD STORY OF THE MEDICAL MISTAKES THAT KILL AND INJURE MILLIONS OF AMERICANS 210–216 (2003) (interviewing patients who suffered from medical injuries and families about their experiences communicating with providers); Kathleen M. Mazor et al., *Understanding Patients' Perceptions of Medical Errors*, 2 J. COMM. HEALTHCARE 34 (2009).

8. Jennifer K. Robbennolt, *What We Know and Don't Know About the Role of Apologies in Resolving Health Care Disputes*, 21 GA. ST. U. L. REV. 1009, 1010–15 (2005) (highlighting that despite legislative interventions to make disclosure of medical error mandatory or to render apologies for medical errors inadmissible as evidence, providers are often advised against disclosures and apologies or any discussion of responsibility).

stress and confusion for the people directly involved,⁹ undermines the delivery of quality care,¹⁰ and leads to additional healthcare costs for patients, their families, and society as a whole.¹¹

One might think that after four decades of legislative reforms to the medical liability system, its capacity for delivering corrective justice by remedying patient harm and preventing future errors should have improved.¹² It has not. This problem persists, in large part, because the predominant focus of state legislators has been on reducing providers' medical liability insurance premiums, not the underlying systemic problems of poor communication and lack of transparency.¹³ Legislators believed, inaccurately, that patient lawsuits directly caused skyrocketing insurance liability premiums and that this "malpractice crisis," which could drive doctors out of business or out-of-state, could be stopped by reducing litigation costs.¹⁴ Consequently, state legislators have passed laws to restrict medical malpractice litigation by making it harder for patients to initiate complaints in court and to prevail once they get there.¹⁵

Recently, the Oregon legislature enacted a law that offers a promising solution to the problems surrounding communication and redress for patient injury. Unlike earlier medical malpractice reforms, Oregon lawmakers constructed a parallel system, an ADR process called Early Discussion and Res-

9. John F. Christensen et al., *The Heart of Darkness: The Impact of Perceived Mistakes on Physicians*, 7 J. GEN. INTERNAL MED. 424, 426 (1992) (conducting in-depth interviews with physicians and finding that, after mistakes leading to "bad outcomes," they had feelings of "fear, guilt, anger, embarrassment, and humiliation [that] were unresolved . . . even a year after the mistake"); Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609, 1612–13 (1994).

10. Jenny Firth-Cozens & Joanne Greenhalgh, *Doctors' Perceptions of the Links Between Stress and Lowered Clinical Care*, 44 SOC. SCI. MED. 1017, 1019–21 (1997).

11. Daniel P. Kessler, *Evaluating the Medical Malpractice System and Options for Reform*, 25 J. ECON. PERSP. 93 (2011); Michelle M. Mello et al., *Who Pays for Medical Errors? An Analysis of Adverse Event Costs, the Medical Liability System, and Incentives for Patient Safety Improvement*, 4 J. EMP. LEGAL STUD. 835 (2007).

12. Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1595–1602 (2002); David Bornstein, *Reducing Preventable Harm in Hospitals*, N.Y. TIMES (Jan. 26, 2016), <http://opinionator.blogs.nytimes.com/2016/01/26/reducing-preventable-harm-in-hospitals/>.

13. See *infra* Part I.C.

14. TOM BAKER, THE MEDICAL MALPRACTICE MYTH 3, 62 (2005) (explaining the relationship between litigation expenses and liability insurance premiums and debunking the theory of direct, positive causality). At different points during the 1970s, 1980s, and again in the early 2000s, medical malpractice insurance premiums increased dramatically. Providers in certain parts of the country and in certain medical specialties found it difficult to obtain and afford liability insurance; for example, from 2000 to 2004, internists in Connecticut saw their premiums increase by over 300%. AM. MED. ASS'N, MEDICAL LIABILITY REFORM NOW!: THE FACTS YOU NEED TO KNOW TO ADDRESS THE BROKEN MEDICAL LIABILITY SYSTEM 9 (2016), <http://ama-assn.org/go/mlrnow>; see also *infra* Part I.C.

15. See *infra* Part I.C.

olution, designed to respond directly to the conventional tort system's inability to deliver corrective justice. The first statewide program of its kind, Early Discussion and Resolution is non-adversarial and does not rely on proving negligence. Instead, it combines early disclosure of adverse healthcare events with a confidential conversation between patients and healthcare providers.¹⁶ The purpose of this new law is to help patients learn about what went wrong, to enable providers to make improvements in healthcare delivery, and to allow the parties to discuss appropriate financial compensation without resorting to litigation and court.¹⁷

Oregon's new law needs to be understood within the larger story of how, and why, states repeatedly use ADR procedural interventions to effect substantive policy outcomes. Successive generations of ADR procedures should be recognized as reflections of policymakers' evolving understanding of the medical liability problem. Starting in the 1970s, state legislatures mandated different kinds of ADR processes, experimenting first with medical screening panels and later with binding arbitration and mediation, both of which became specialized procedures for medical malpractice claims.¹⁸ These specialized ADR procedures, however, were components of the larger legislative response intended to make it harder for patients to bring malpractice claims; accordingly, they functioned as roadblocks, restricting access to courts or limiting opportunities for judicial intervention. In contrast, Oregon's new, specialized ADR process attempts to address the problems of poor communication and lack of transparency, both of which contribute to cycles of patient injury, inadequate compensation, and missed opportunities for providers to learn from mistakes.¹⁹ Thus, Oregon's approach not only creates a novel ADR process designed to achieve new reform objectives, but also it completely reimagines the utility of ADR for medical malpractice reform.

This Article argues that experimentation with ADR procedural interventions has been an critical component in the medical malpractice "testing ground" for new tort reforms.²⁰ And, most importantly, these ADR interventions have come to rely less and less on formal substantive and procedural law, demonstrating that principles of both tort and adversarial legalism are a "poor fit" for addressing the incidence of medical error in the modern

16. Resolution of Adverse Health Incidents Act, ch. 5, § 1(1), 2013 Or. Laws 1, 1 (codified at OR. REV. STAT. ANN. §§ 30.278, 31.250, 743.056 (West 2016)) [hereinafter Adverse Health Incidents Act]. See *infra* Part III.B.1.

17. See *infra* Part IV.

18. See *infra* Part II.

19. See *infra* Part IV.

20. PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 33 (1991) ("Medical malpractice has served as the major testing ground not only for new tort doctrines but also for empirical research about the real-world impact of new laws.").

healthcare system.²¹ Indeed, the latest experiment in Oregon constructs a whole new approach to corrective justice in the medical liability context that does not depend on proving negligence at all. However, while this distancing from the conventional tort system has the potential to address the patient safety problem in ways previous ADR reforms could not, it also introduces new challenges that will need to be addressed if the patient safety reform project is to succeed. Should other states seek to reform the culture around addressing and redressing harm to patients by implementing Early Discussion and Resolution programs, additional protections will be critical to ensure that patients, providers, and the public can all be protected in this alternative system.

To make this argument, the Article proceeds in five parts. Part I explains how the current tort system fails to accomplish its goals of compensation and deterrence. Instead of directly addressing these system failures, early reform efforts focused on restricting litigation to contain the costs of medical liability insurance premiums for providers. Part II discusses the three forms of ADR legislators initially deployed to limit malpractice litigation—medical screening panels, binding arbitration, and mandatory mediation—and presents research showing that they have largely been ineffective. Part III introduces the patient safety movement and one alternative corrective justice model it inspired, called “early communication and resolution.” Part IV examines Oregon’s Early Discussion and Resolution program, an ADR-based alternative to the traditional tort system that aims to improve prevention and compensation of patient injury. Although Oregon’s program shows early promise, it also raises new concerns that will need to be addressed in order to meet its reform objectives. In Part V, the Article concludes with additional observations about the diminishing role of common law tort and adversarialism in responding to and resolving patient injury disputes.

I. A MEDICAL MALPRACTICE SYSTEM IN NEED OF REFORM

When a sick patient undergoes medical treatment, the hope and expectation is that everything will go according to plan. But sometimes mistakes and accidents happen during treatment that injure a patient, prolonging recovery or sometimes causing death. These iatrogenic injuries, or adverse

21. Mello & Brennan, *supra* note 12, at 1618 (using the phrase “poor fit” to describe the mismatch between instances of provider negligence and patient lawsuits).

outcomes caused by the medical treatment itself and not the underlying illness, are sometimes anticipated because the medical treatment is inherently risky.²² But, sometimes the injury results from simple human error.²³

For example, a neurosurgeon removing a spinal cord tumor might inadvertently damage nerves during the procedure and cause his patient to become paralyzed down the right side of her body.²⁴ In this case, the patient's paralysis, while certainly an iatrogenic injury caused by the medical intervention, was not preventable. The injury was a consequence of a risky surgery and not the result of the physician's inattention or failure to comply with accepted surgical standards. Contrast this neurosurgery example with the example of an adverse drug event. A busy doctor, prescribing a new blood-pressure medication to an elderly patient, forgets to check whether the patient is also taking anti-depressants, which can sometimes lower blood sodium levels.²⁵ After taking the new medication, the patient's blood pressure drops precipitously and he collapses, hits his head, and suffers seizures and broken bones.²⁶ This case also involves a patient injury caused by medical treatment but, unlike the neurosurgery example, the iatrogenic injury was the result of an error that could have been prevented had the physician first consulted the

22. The medical injury terminology can be baffling. First, one must distinguish between iatrogenic and non-iatrogenic adverse outcomes or injuries. Then, within the category of iatrogenic injuries, one must further distinguish between those that were or were not caused by a preventable error. As the IOM report explains:

An adverse event is an injury resulting from a medical intervention, or in other words, it is not due to the underlying condition of the patient. While all adverse events result from medical management, not all are preventable (i.e., not all are attributable to errors). For example, if a patient has surgery and dies from pneumonia he or she got postoperatively, it is an adverse event. If analysis of the case reveals that the patient got pneumonia because of poor hand washing or instrument cleaning techniques by staff, the adverse event was preventable (attributable to an error of execution). But the analysis may conclude that no error occurred and the patient would be presumed to have had a difficult surgery and recovery (not a preventable adverse event).

INST. OF MED., *supra* note 1, at 4 app. C. For a taxonomy of terms in the surgical setting, see INST. OF MED., *supra* note 1, at 210 app. B, Nancy C. Elder & Susan M. Dovey, *Classification of Medical Errors and Preventable Adverse Events in Primary Care: A Synthesis of the Literature*, 51 J. FAM. PRACTICE 927 (2002), and Jeffrey Phillip Jacobs et al., *The Nomenclature of Safety and Quality of Care for Patients with Congenital Cardiac Disease: A Report of the Society of Thoracic Surgeons Congenital Database Taskforce Subcommittee on Patient Safety*, 18 CARDIOLOGY YOUNG 81 (2008).

23. It is important to note that when providers obtain informed consent from patients by detailing all the potential anticipated and unanticipated adverse outcomes possible in any medical treatment, such consent *only* covers events that were not preventable; therefore, it does not excuse those events caused by improper provider practice or systemic error.

24. See HENRY MARSH, DO NO HARM: STORIES OF LIFE, DEATH, AND BRAIN SURGERY 4–5 (2015) (discussing a similar scenario from which the neurosurgery example is adapted).

25. See Jane E. Brody, *Too Many Pills for Aging Patients*, N.Y. TIMES (Apr. 16, 2012), http://well.blogs.nytimes.com/2012/04/16/too-many-pills-for-aging-patients/?_r=0 (discussing a similar scenario from which the anti-depressant example is adapted).

26. *Id.*

patient's records.²⁷ Thus, there is an important categorical distinction between patient injuries caused by a preventable error in the medical treatment itself and an adverse outcome of medical treatment that, while one would certainly hope to avoid, was anticipated.

Injured patients may have some form of health insurance to defray a portion of their added medical costs.²⁸ However, their health insurance coverage may have a high deductible, requiring substantial out-of-pocket payment before providing coverage. Furthermore, health insurance may not cover long-term rehabilitation or custodial care and will not compensate lost wages or pain endured. And, in the event a patient dies, health insurance will not cover burial or funeral arrangements.

How do patients and their families obtain recompense? In the United States, they turn to the tort system. The legal system provides an avenue to assess and redress patient injuries through medical malpractice litigation. The ability of the medical malpractice system to compensate wrongfully injured plaintiffs and deter negligence, however, is far from ideal. This Part briefly explains the theoretical foundations of the malpractice system and then discusses some of the real and perceived problems propelling system reform efforts, including the ADR interventions that are the focus of this Article.

A. *The Corrective Theory of Tort*

Medical malpractice liability is grounded in tort. A central principle of tort is that a person harmed by someone else's misbehavior should not have to bear the burden of the injury.²⁹ The tort system's two-part mission is to dispense "corrective justice" on the one hand and to deter carelessness on the other. The "correction" of corrective justice refers to shifting responsibility for the harm from the victim to the culpable party.³⁰ To enable this "correction," the tort lawsuit sets up a "contest between two parties" and asks whether the plaintiff's loss is the fault of the defendant and whether that loss was a foreseeable consequence of the defendant's action.³¹ To prevail, the

27. Studies indicate that adverse drug events (referred to in the literature as "ADEs"), particularly among the elderly, are a serious problem in the United States. See, e.g., Daniel S. Budnitz et al., *National Surveillance of Emergency Department Visits for Outpatient Adverse Drug Events*, 296 JAMA 1858 (2006); Jerry H. Gurwitz, *Incidence and Preventability of Adverse Drug Events Among Older Persons in the Ambulatory Setting*, 289 JAMA 1107 (2003).

28. The Center for Disease Control's National Center for Health Statistics reported in 2014 that 11.5% of the U.S. civilian non-institutionalized population lacked health insurance. ROBIN A. COHEN & MICHAEL E. MARTINEZ, NAT'L CTR. FOR HEALTH STATISTICS, HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY 2014, at 1 (2015), <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201506.pdf>.

29. Ernest J. Weinrib, *Corrective Justice*, 77 IOWA L. REV. 403, 410 (1992).

30. *Id.* at 408–10 (explaining that the Aristotelian account of corrective justice treats the defendant's unjust gain as correlative to the plaintiff's loss).

31. WEILER, *supra* note 20, at 44–45.

plaintiff must establish that the defendant owed a duty of care to that plaintiff, the defendant failed in her duty, and that failure proximately caused the plaintiff's injury.

In its most basic form, negligent medical care, or medical malpractice, is the failure to do what a reasonable provider in the same specialty would have done under the same or similar circumstances.³² Taking the examples discussed earlier, the neurosurgeon would not be found negligent and liable for the patient's paralysis because his actions in removing the tumor constituted reasonable, standard practice. The doctor who failed to check the elderly patient's existing prescriptions could be considered negligent and responsible for the patient's injuries if, first, the patient could demonstrate that his injuries were a foreseeable result of drug interaction and, second, that another doctor in the same or similar circumstance would have consulted the medical chart, seen the prior prescriptions, and made a different decision.³³

If a judge or jury finds that a patient's injury was caused by a doctor's substandard care, then the patient is entitled to compensation for financial losses, such as lost earnings, medical bills, and other associated costs, as well as non-financial losses, such as pain and suffering.³⁴ It is this attachment of liability to the doctor's actions and judgments that comprises the deterrence component of the tort system. In theory, doctors will be incentivized to take care when treating future patients in order to avoid becoming professionally and financially responsible for a patient's injuries.³⁵ In reality, however, the tort system does not function so smoothly.

B. The Realities of the Medical Malpractice System

The medical malpractice system falls short of reaching both its objectives—the corrective justice mission of compensating victims and the goal of

32. DOUGLAS A. HASTINGS ET AL., NAT'L HEALTH LAWYERS ASS'N, FUNDAMENTALS OF HEALTH LAW 136 (1995); RESTATEMENT (THIRD) OF TORTS: PHYSICAL & EMOTIONAL HARM § 3 (AM. LAW. INST. 2010) ("Primary factors to consider in ascertaining whether the person's conduct lacks reasonable care are the foreseeable likelihood that the person's conduct will result in harm, the foreseeable severity of any harm that may ensue, and the burden of precautions to eliminate or reduce the risk of harm.").

33. Proving causation in the medical malpractice context is notoriously difficult. Patients go to providers when they are already sick or injured and there is rarely universal consensus on what standard treatments should be for a particular patient. Thus, given the complexities, diverse opinions, and risks of modern medical treatments, it can be extremely hard to tell whether a death or disability occurred because of a mistake or not. BAKER, *supra* note 14, at 15–16.

34. PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 14 (1993). Medical malpractice suits can involve providers other than physicians, though most states label malpractice by a non-physician health care provider as "professional negligence." *E.g.*, NEV. REV. STAT. ANN. §§ 41A.009, 41A.015 (LexisNexis 2012).

35. WEILER ET AL., *supra* note 34, at 14–15.

detering future negligence. Although most policymakers agree that the system needs reform, there is less agreement around the reasons for its shortcomings.

Scholars and researchers have identified an array of problems with the medical malpractice system. For example, when it comes to compensating patients, the increasing cost, complexity, and interconnectedness of delivering and paying for modern healthcare not only makes the preliminary question of proximate causation difficult to prove in all but the most extreme cases, but it also means payouts in patient compensation for those few extreme cases are tremendously high.³⁶ In addition, the rise of managed care organizations insulates providers from the intended deterrent effect of the tort system.³⁷ Additional culprits identified for the poorly functioning medical liability system include the competitive nature of the medical malpractice insurance market and the imperfect actuarial assessments insurance carriers rely upon,³⁸ as well as the economic³⁹ and psychological⁴⁰ realities of bringing a lawsuit and getting sued in the American civil justice system. Layered

36. See, e.g., MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM (William M. Sage & Rogan Kersh eds., 2006) (covering the wide-ranging and multidimensional problems underlying the medical malpractice crisis).

37. Mello & Brennan, *supra* note 12, at 1603; see also Edward A. Dauer, *When the Law Gets in the Way: The Dissonant Link of Deterrence and Compensation in the Law of Medical Malpractice*, 28 CAP. U. L. REV. 293 (2000) (discussing how tort's theories of deterrence and compensation are supposed to work and why they do not); Philip G. Peters, Jr., *Resuscitating Hospital Enterprise Liability*, 73 MO. L. REV. 369, 371–85 (2008) (arguing that an exclusive hospital enterprise liability system would deter future errors better than the current malpractice regime by holding health care delivery organizations (hospitals and managed care organizations) liable rather than individual providers).

38. See, e.g., BAKER, *supra* note 14 (detailing the nature of medical malpractice liability insurance and its contribution to the malpractice crisis); FRANK A. SLOAN & LINDSEY M. CHEPKE, MEDICAL MALPRACTICE (2008) (explaining the medical malpractice crisis and recommending policy reforms).

39. Stephen Daniels & Joanne Martin, *Plaintiffs' Lawyers, Specialization, and Medical Malpractice*, 59 VAND. L. REV. 1051, 1061–66 (2006) (explaining economics of medical malpractice litigation for most plaintiffs' attorneys). Medical malpractice attorneys are particularly "ruthless" when it comes to screening, often accepting fewer than ten percent of all cases that come to them:

The reasons for not taking low-value cases even though there may be malpractice involved is simple. There must be enough potential for recovery to pay for the costs of screening the case, the costs of preparing the case, the costs of actually litigating the case, the cost of the lawyer's time, and possibly the cost of a referral fee to the lawyer who brought the case to the specialist. On top of this, there must be enough financial recovery to help pay for the costs of screening all of the cases ultimately rejected by the lawyer, as well as other parts of the lawyer's overhead.

Id. at 1064. Those people whose claims are not selected by medical malpractice plaintiffs' attorneys have few options for legal representation and may turn to law firms that run high volume "settlement mills." For a discussion of this kind of personal injury legal practice, see Nora Freeman Engstrom, *Run-of-the-Mill Justice*, 22 GEO. J. LEGAL ETHICS 1486 (2009).

40. See, e.g., Jennifer K. Robbenolt & Valerie P. Hans, *The Psychology of Tort Law*, in 1 ADVANCES IN PSYCHOLOGY AND LAW 249 (Monica K. Miller & Brian H. Bornstein eds., 2016) (drawing attention to the multiple connections between how the tort system operates and the human psychology of its key players—patients, providers, attorneys, insurers, judges and jurors); Kessler,

on top of these issues is a multiplicity of state and federal regulations⁴¹ and, adding in the political rhetoric of “crisis,” the result is one complicated, snarled problem.⁴²

This Section focuses on two significant problems with how the conventional tort system operates. First, a substantial number of patients are injured by mistakes in their medical treatment, yet the overwhelming majority never access the tort system to receive corrective compensation. Second, providers’ sensitivity about malpractice accusations results in unproductive behaviors that make it harder to deter future mistakes in medical treatment.

1. Patient Injuries Without Compensation

When it comes to compensating injured patients, the medical malpractice system’s performance is far from optimal. A well-functioning system would consistently remunerate as many negligently injured patients as possible.⁴³ Instead, researchers find that the majority of such patients do not receive compensation because they never seek it and there is little connection between those patients who actually suffer negligent injuries and those who ultimately file malpractice claims.⁴⁴

supra note 11, at 93, 95 (exploring the empirical question of whether, and how, tort reforms impact physician behavior and decisionmaking); Barbara J. Youngberg & Catalina Soto, *Litigation Stress Support Groups for Healthcare Professionals: Risk Manager’s Role*, 10 J. HEALTHCARE RISK MGMT. 14 (1990) (discussing “litigation stress syndrome”).

41. For example, the 1986 Healthcare Quality Improvement Act established a National Practitioner Data Bank and required providers and their liability insurers to report any payments made in response to a medical malpractice claim or face sanctions. 42 U.S.C. §§ 11131–11137 (2012). There are also voluntary and mandatory reporting systems for disclosing when adverse healthcare incidents occur. See Lucian L. Leape, *Reporting of Adverse Events*, 347 NEW ENG. J. MED. 1633, 1633–35 (2002).

42. For an engaging history of the politics surrounding medical malpractice and healthcare reform, see Rogan Kersch, *Medical Malpractice and the New Politics of Healthcare*, in MEDICAL MALPRACTICE AND THE U.S. HEALTHCARE SYSTEM, *supra* note 36, at 43–44. See also Douglas A. Kysar et al., *Medical Malpractice Myths and Realities: Why an Insurance Crisis Is Not a Lawsuit Crisis*, 39 LOY. L.A. L. REV. 785 (2006).

43. See, e.g., *supra* Part I.A and notes 29–42.

44. These trends are not new. The major and oft-cited studies supporting and verifying these findings use data gathered in the 1970s and 80s. See PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 18–25 (1985); Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370 (1991); Lucian L. Leape et al., *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II*, 324 NEW ENG. J. MED. 377 (1991); A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245 (1991). For an expanded discussion of these studies’ methodologies and other findings, see BAKER, *supra* note 14, at 24–38. For discussion of how socioeconomic structures impact injured patients’ behavior and failure to claim, see Richard L. Abel, *The Real Tort Crisis—Too Few Claims*, 48 OHIO ST. L. J. 443, 448–52 (1987).

In fact, only a tiny fraction of patients who suffer negligent injuries pursue compensation by filing a malpractice claim. The earliest study in California gathered 21,000 patient records from twenty-four California hospitals and compared them to subsequent malpractice claim filings. The study found that, at most, ten percent of patients who were victims of negligent medical treatment filed lawsuits and an even smaller percentage of those claims resulted in compensation.⁴⁵ Another study evaluated 31,000 patient records from fifty hospitals in New York searching for injuries caused by substandard care, and also investigated 3,500 malpractice claim filings, ultimately comparing the two data sets and finding that less than two percent of persons injured by negligence filed a claim.⁴⁶ A related study comparing patient hospital records to subsequent malpractice claim filing records in Colorado and Utah found that only 2.5% of negligently injured patients filed claims.⁴⁷

Although there is only a sliver of overlap between those patients who suffer medical injuries caused by negligence and those who pursue malpractice claims for compensation, studies find that the malpractice system does a reasonable job of sorting valid from invalid claims. The pool of claimants includes individuals who cannot demonstrate legal negligence,⁴⁸ yet those people rarely receive settlement payouts or court awards.⁴⁹

45. DANZON, *supra* note 44, at 24.

46. Localio et al., *supra* note 44, at 245.

47. David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250, 255–57 (2000) (linking 14,700 patient medical records to four years of medical malpractice claiming data and finding not only that real victims of medical negligence almost never file suit to receive compensation, but also that the people in this “worthy-but-uncompensated group” were more likely to be poor and elderly).

48. David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2028 (2006) [hereinafter Studdert et al., *Claims*] (concluding that out of 1,452 malpractice claims, 97% of claims involved injury but, of those 1,406 cases, 63% were due to error and 37% did not include error). The 2000 study of malpractice claims in Utah and Colorado found that 78% of claims involved neither injury nor negligent care. Studdert et al., *supra* note 47, at 253–54.

49. BAKER, *supra* note 14, at 68–87 (summarizing studies of malpractice claiming and litigation outcomes); David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1092–1104 (2006) (explaining results of empirical studies debunking the theory that patients with invalid, frivolous claims receive compensation); Studdert et al., *Claims*, *supra* note 48, at 2031 (finding that, although claims without evidence of error are not uncommon, the vast majority of expenditures go to litigation and payment in cases involving error); PUBLIC CITIZEN, *THE GREAT MEDICAL MALPRACTICE HOAX: NPDB DATA CONTINUE TO SHOW MEDICAL LIABILITY SYSTEM PRODUCES RATIONAL OUTCOMES* (2007) (summarizing data from the National Practitioner Data Bank showing the malpractice system provides money for valid claims and dismisses those found invalid). *But see* Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963 (1996) (finding that severity and permanence of injury were more determinative of compensation than whether the injury was determined to be caused by negligence).

The few parties that do not settle their claims and instead pursue court litigation face a lengthy,⁵⁰ expensive,⁵¹ and inefficient⁵² process. Liability insurance companies bear the costs of defending claims whether they ultimately win or lose.⁵³ Plaintiffs that succeed in securing compensation for injuries arising from negligence usually only retain around sixty percent of the award, which may already be constrained by the providers' liability insurance policy limit,⁵⁴ with the remainder going to pay attorney fees and litigation expenses.⁵⁵

So why do patients file claims if they get so little in return? Research shows that claimants are often motivated by a desire for information rather than financial compensation.⁵⁶ Patients seek greater honesty from providers, acknowledgment of the harm suffered, and reassurance that the mistake will not be repeated in the future.⁵⁷ One famous study of parents whose children were neurologically impaired at birth found that twenty-four percent of parents filed because they thought the provider was not completely honest or

50. Studdert et al., *Claims*, *supra* note 48, at 2024, 2026, 2031 (noting the average time between occurrence of the injury and closure of the claim was five years and that one in three claims took more than six years to resolve).

51. *Id.* at 2026–27, 2031 (estimating that average compensation paid to plaintiffs ranges from \$799,365 (out of court settlement) to \$462,099 (trial verdict awards), a third of which goes to pay attorney fees and other costs; and the costs of defending malpractice claims average from \$42,015 (cases resolved out of court) to \$112,968 (cases resolved by trial)).

52. For every dollar spent on medical malpractice liability insurance, only forty cents reaches injured patients as compensation, with another forty cents going to pay legal fees, and the remaining twenty cents for insurance overhead. Michelle M. Mello & David M. Studdert, *The Medical Malpractice System: Structure and Performance*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTHCARE SYSTEM*, *supra* note 36, at 11, 22 (citing Patricia M. Danzon, *Liability for Medical Malpractice*, in *HANDBOOK OF HEALTH ECONOMICS* 1344 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000)).

53. Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 *HEALTH AFF.* 1569, 1572 (2010) (for every dollar paid in patient compensation, an additional nineteen cents are paid defending the claim).

54. Charles Silver et al., *Policy Limits, Payouts, and Blood Money: Medical Malpractice Settlements in the Shadow of Insurance*, 5 *U.C. IRVINE L. REV.* 559, 579–83 (2015). Using an extended data set than previously used in earlier studies, researchers found that physicians are purchasing less liability insurance coverage—i.e., purchasing policies with limits of \$100,000–\$200,000 rather than \$500,000–\$1 million. Researchers concluded that these policies operate as *de facto* limits on the amount injured patients can recover and offer a number of hypotheses, including that plaintiffs' attorneys may not be motivated to pursue providers' personal assets in all but the most egregious cases. *Id.*

55. WEILER, *supra* note 20, at 61–64 (noting that although under contingency fee arrangements plaintiffs generally pay nothing if they lose, attorneys tend to bill more in each case so that, if they win, the fees recouped can cover losses in other cases); *see also* SLOAN & CHEPKE, *supra* note 38, at 135–45 (explaining the history and economics of contingent fee arrangements).

56. Hyman & Silver, *supra* note 49, at 1113–16 (explaining why patients do not sue—such as lack of information about the error, injuries determined too minor and/or already covered by health insurance, reluctance to damage relationship with provider and engage in lengthy and unpredictable litigation—and why patients do sue—such as severe injuries, inadequate healthcare insurance, irritation with providers over failure to communicate).

57. Vincent et al., *supra* note 9, at 1612–13.

lied; twenty percent of parents filed because they could not get anyone to tell them what happened; and nineteen percent said they filed out of anger, revenge or a desire to ensure it would not happen to anyone else.⁵⁸ Therefore, for patients who perceive their providers as insufficiently candid or forthcoming with information after an adverse medical event, litigation offers a means to obtain answers to the questions of what happened and whether it could have been prevented.⁵⁹ The next Section explores some reasons for providers' lack of communication.

2. Failures in Prevention and Communication

The malpractice system also fails to achieve its second important objective: deterrence of provider behavior resulting in mistakes in medical treatment. In theory, for deterrence to work, the targeted actors must know what standards are expected of them, act rationally in weighing risks and benefits of different actions, and directly experience the negative impact of their careless behavior.⁶⁰

Research into the legal structure and economic incentives of the medical malpractice system demonstrates that, in reality, this theoretical calculus fails to add up. First, the standards applicable to providers are not always clear: opinions about medical treatment can vary widely, making it difficult to identify which medical judgments are negligent and which are not.⁶¹ Second, providers have a difficult time self-monitoring their behavior with reasoned, cost-benefit analysis because the malpractice system appears unpredictable, a distortion partly due to the small numbers of claims and disproportionate targeting of providers in high-risk subspecialties such as obstetrics.⁶² Third,

58. Gerald B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1361 (1992) (other reasons for filing included that parents needed money for their child's future care and that they were advised to sue by someone else, usually a medical professional); see also Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROBS. 185, 201-04 (1997) (summarizing research studies of why patients sue their providers).

59. BAKER, *supra* note 14, at 84 (citing Henry S. Farber & Michelle J. White, *Medical Malpractice: An Empirical Examination of the Litigation Process*, 22 RAND J. ECON. 199, 216 (1990)); Henry S. Farber & Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777, 778 (1994) [hereinafter Farber & White, *A Comparison*]. These studies found that patients use litigation to find out if a hospital was negligent. Cases involving clear evidence of either good or bad quality of care were dropped or settled, respectively, earlier than those cases where evidence was ambiguous.

60. Mello & Studdert, *supra* note 52, at 18; see also Mello & Brennan, *supra* note 12, at 1602-03.

61. See, e.g., Eric J. Thomas et al., *The Reliability of Medical Record Review for Estimating Adverse Event Rates*, 136 ANN. INTERNAL MED. 812-14 (2002) (discussing a study in which physicians reviewed 500 medical records for adverse events and negligence and found that there was poor to moderate reliability among the physicians' determinations of appropriate standard of care).

62. Scholars and researchers find that providers perceive the malpractice system as random. Providers broadly alter their behavior to protect themselves in the event of a lawsuit rather than to

careless providers do not directly feel the immediate impact of their mistakes because so few negligently injured patients bring claims.⁶³ And, malpractice liability insurance frequently shields bad actors from paying injured patients out of their own pockets. Thus, bad actors may not see a resultant increase in their liability premiums any more than the good actors included in the same insurance plan.⁶⁴ Thus, the malpractice system does not effectively deter providers' negligent behavior.

Instead, the menace of tort litigation deters constructive, positive behavior such as open communication between patients and providers. For example, providers may avoid talking to a patient about an adverse outcome from medical treatment, explaining what occurred, or apologizing, for fear that what they say will later be used against them later in litigation.⁶⁵ As a consequence, providers can engage in "bristling" and "cloaking" behaviors, which interfere with the patient-provider relationship and open communication.⁶⁶ Many providers respond to the threat of tort litigation by practicing defensive medicine as a prophylactic against a future finding of negligence, further adding to healthcare system costs that may not benefit and could even harm patients.⁶⁷ There are many reasons for defensive medicine but one is

prevent injury in a given instance. Moreover, the interconnected nature of modern medicine makes it difficult to target single careless actors. See, e.g., SLOAN & CHEPKE, *supra* note 38, at 189–215; WEILER, *supra* note 20, at 70–92, 105–13; WEILER ET AL., *supra* note 34, at 111–34; Kessler, *supra* note 11, at 93; Mello & Brennan, *supra* note 12, at 1595; Mello & Studdert, *supra* note 52, at 17–21, 23–29.

63. WEILER ET AL., *supra* note 34, at 18–19, 112–17.

64. Peter A. Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 SYRACUSE L. REV. 939, 949–64 (1984).

65. Gallagher et al., *supra* note 6, at 1001; Lamb et al., *supra* note 6, at 73; Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553 (1997); Robbennolt *supra* note 8, at 1012.

66. Mello & Studdert, *supra* note 52, at 25–29 ("bristling behaviors" arise from provider suspicion and distrust of their patients, causing them to behave less personably, practice without liability insurance, or require patients to sign liability waivers; "cloaking behaviors" include lack of communication and reporting of errors). The negative psychological impact of malpractice litigation on doctors and patients is profound—and not new. See, e.g., Troyen A. Brennan et al., *Liability, Patient Safety, and Defensive Medicine: What Does the Future Hold?*, in MEDICAL MALPRACTICE AND THE U.S. HEALTHCARE SYSTEM, *supra* note 36, at 93, 110 ("The charge of negligence is felt as an unwarranted criminal accusation, and the doctor immediately becomes the victim."); Maevé Ennis & Charles Vincent, *The Effects of Medical Accidents and Litigation on Doctors and Patients*, 16 LAW & POL'Y 97 (1994); Daniel P. Kessler, *supra* note 11, at 93; Youngberg & Soto, *supra* note 40 (discussing "litigation stress syndrome"); see also Marshall B. Kapp, *Medical Error Versus Malpractice*, 1 DEPAUL J. HEALTHCARE L. 751, 755–57 (1997) (discussing the culture of infallibility among providers).

67. Mello et al., *supra* note 53, at 1574–75 (estimating the annual costs of the medical liability system, including defensive medicine, to be \$55.6 billion, which constituted 2.4% of total national healthcare spending in 2008); David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2612–14 (2005) (surveying 824 physicians practicing in high-risk specialties and finding that ninety-three percent practiced defensive medicine (e.g., ordered more tests than patients needed; suggested invasive procedures not medically indicated; prescribed unnecessary medications; avoided caring for high

existing federal legislation requiring providers and their liability insurers to report any payment made in response to a medical malpractice claim to the National Practitioner Data Bank (“NPDB”)⁶⁸ or else face sanctions.⁶⁹ Providers are therefore reluctant to agree to even nominal settlements because they trigger reporting requirements, implying fault and tarnishing reputations.⁷⁰ These factors combine to create a strong culture of “deny and defend,” with many providers strongly opposed to compromising on claims, particularly those lacking clear evidence of negligence.⁷¹ Thus, the conventional tort system creates an environment where providers fail to address unanticipated mistakes in medical treatment and, as a result, do not learn how to prevent them in the future.

C. Malpractice “Crisis” and Reform Response

Given the inherent problems with the medical liability system, it is no wonder that the system has long been the target of legislative reform efforts at both the state and federal levels.⁷² However, despite the ineffectiveness, inaccuracy, and inefficiency of the tort system, reformers have not addressed the compensation and deterrence problems, at least until quite recently.⁷³

Instead, traditional reform efforts focused on something else entirely: reducing the cost of providers’ medical liability insurance premiums. Behind these reform efforts is a fear that inaccessibility and unaffordability of professional liability insurance for providers would drive them out of practice and cause shortages of healthcare delivery.⁷⁴

Liability insurance plays a critical role in the medical malpractice system. Providers and healthcare facilities, such as hospitals and nursing homes, regularly purchase medical malpractice liability insurance in the event they

risk patients altogether), particularly those who distrusted their liability coverage or perceived their liability insurance premiums as too burdensome).

68. See *infra* Part IV.C.2.

69. See *supra* note 41.

70. See Katharine A. Van Tassel, *Blacklisted: The Constitutionality of the Federal System of Publishing Reports of “Bad” Doctors in the National Practitioner Data Bank*, 33 CARDOZO L. REV. 2031, 2057–62 (2012).

71. Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203, 205–06 (1996) (stating that providers accused of malpractice want “to ‘clear their names’ . . . [and] are disinclined to approve settlements”). For further discussion on the concept of “deny and defend,” see Richard C. Boothman et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 J. HEALTH & LIFE SCI. 125 (2009).

72. For an exceptionally thorough discussion of the history, ideology, economics, methods, and subjects of various tort reform efforts through the ages, see F. Patrick Hubbard, *The Nature and Impact of the “Tort Reform” Movement*, 35 HOFSTRA L. REV. 437 (2007).

73. See *infra* Part III.

74. BAKER, *supra* note 14, at 64–65 (explaining the difficulty in accessing and affording malpractice insurance for providers in certain areas of the country and in certain subspecialties).

are sued.⁷⁵ Providers pay insurance carriers monthly premiums and, in exchange, insurance companies cover costs associated with defending claims and paying compensation awards to successful plaintiffs.⁷⁶ As in other forms of insurance, premiums adjust to reflect the degree of risk involved in a provider's specialty, the provider's past history and experience, and the geographic area of the provider's medical practice.⁷⁷

Periodically, the affordability and availability of liability insurance for providers become issues of concern. Most notably, in the early 1970s, liability insurance became unavailable in some parts of the country.⁷⁸ Liability insurance again became unavailable or prohibitively expensive in the mid-1980s and early 2000s, when insurance rates jumped and providers lacked sufficient revenue to absorb those higher premiums.⁷⁹ The sharp increase in premiums stoked fears that providers, unable to afford the cost of practicing medicine, would shutter their offices and clinics and either relocate to a less expensive jurisdiction or stop practicing altogether.⁸⁰

75. Indeed, many states require doctors to carry malpractice insurance as a condition of their medical license. *See, e.g.*, COLO. REV. STAT. ANN. § 13-64-301 (West 2016) (requiring every physician, dentist, dental hygienist, and health care institution to maintain set amounts of liability insurance coverage); CONN. GEN. STAT. ANN. § 20-11b (West 2016) (requiring physicians to maintain at least \$500,000 of professional liability insurance coverage for an individual occurrence and \$1.5 million for aggregate incidents); 63 PA. CONS. STAT. § 122.2 (West 2016) (requiring dentists to maintain medical professional liability insurance).

76. Standard provider policies provide \$1 million coverage per incident and a maximum of \$3 million per year. There are multiple layers of insurance coverage: providers and the healthcare organizations often purchase their own complementary policies or states provide a second-layer of coverage through a patient compensation fund. Mello & Studdert, *supra* note 52, at 14–15.

77. In 2009, an obstetrician practicing in Long Island paid \$178,000 in insurance premiums while an internist paid \$33,000, with the same specialists in Colorado each paying a third as much. Kessler, *supra* note 11, at 94 (citing RATE SURVEY, MEDICAL LIABILITY MONITOR (2009)).

78. *See* SLOAN & CHEPKE, *supra* note 38, at 27–50.

79. WEILER, *supra* note 20, at 4. Between 1988 and 1991, many providers saw their malpractice insurance premiums go from six percent of their gross revenue to twenty-five percent. *Id.* During the 2000–2004 crisis, the American Medical Association tracked premium increases, which showed significant jumps for obstetricians and gynecologists (in Miami-Dade, Florida, premiums increased from \$147,621 to \$277,241), general surgeons (in Philadelphia, metropolitan area premiums increased from \$33,684 to \$128,524); and internists (in Connecticut, premiums increased from \$7,736 to \$28,917). *Id.*; *see also* AM. MED. ASS'N, *supra* note 14, at 9.

80. These fears derive from anecdotes and have not been substantiated in empirical studies. One study found that increases in malpractice liability premiums had no effect on provider relocation with the one exception for providers in certain rural areas. Katherine Baicker & Amitabh Chandra, *The Effect of Malpractice Liability on the Delivery of Health Care*, 8 FRONTIERS IN HEALTH POL'Y RES. 1 (2005). Other studies found that providers and hospitals often pass the cost of premium hikes on to consumers and health insurance companies, although that can be harder for providers with fee-for-service reimbursement arrangements with insurers like Medicare and Medicaid that pay a fixed price. *See, e.g.*, Mark V. Pauly, *Who Pays When Malpractice Premiums Rise?*, in MEDICAL MALPRACTICE AND THE U.S. HEALTHCARE SYSTEM, *supra* note 36, at 71–83; Patricia M. Danzon et al., *The Effects of Malpractice Litigation on Physicians' Fees and Incomes*, 80 AM. ECON. REV. 122 (1990). For a collection of anecdotes about premium hikes, hospital closures, and malpractice insurance bankruptcies in various states, see SLOAN & CHEPKE, *supra* note 38, at 63–64 box 3.1.

The reasons for these fluctuations in liability insurance are complex and not directly connected to litigation rates. Indeed, liability insurance unavailability and the rise and fall in premiums appear to occur cyclically.⁸¹ These cycles follow a confluence of macro-economic factors,⁸² market competition among liability insurance carriers,⁸³ and off-target actuarial predictions about projected insurance costs.⁸⁴ The intermingling of these contributing factors affect insurance companies' loss ratios at different points in time, requiring them to make up for unanticipated shortfalls by increasing providers' premiums quickly.⁸⁵

This complex picture did not inform policymakers' reforms; instead, many assumed, incorrectly, that liability premium increases resulted directly from increased litigation. Reform advocates blamed the frequency of patient-initiated litigation and the magnitude of liability insurance payouts for liability insurance premium hikes.⁸⁶ As a consequence, what was a medical malpractice *insurance* crisis became publicly branded as a "medical malpractice crisis" demanding tort reform.⁸⁷ Numerous empirical studies, however, have shown that these assumptions were misinformed.⁸⁸

State policymakers reacted to the perceived problem of excessive malpractice litigation by passing an "onslaught" of laws making it more difficult for patients to sue and prevail.⁸⁹ Concluding that mid-century changes in tort

81. For a detailed discussion of the insurance market and how it fits into malpractice litigation, see ERIC NORDMAN ET AL., NAT'L ASS'N INS. COMMISSIONERS, MEDICAL MALPRACTICE INSURANCE REPORT: A STUDY OF MARKET CONDITIONS AND POTENTIAL SOLUTIONS TO THE RECENT CRISIS (2004).

82. SLOAN & CHEPKE, *supra* note 38, at 44–46.

83. *Id.* at 39–44.

84. BAKER, *supra* note 14, at 51–58 (explaining the actuarial calculations underwriters use to predict future losses and how much or how little money to reserve for claims).

85. David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 285 (2004). A loss ratio is the ratio of an insurance company's payments and administrative costs to premiums collected.

86. STEPHEN DANIELS & JOANNE MARTIN, CIVIL JURIES AND THE POLITICS OF REFORM 92–102 (1995) (examining the rhetorical claims and devices of medical malpractice reformers in the 1980s and early 1990s).

87. Tort reform is a highly politicized issue. This Article deliberately attempts to cut through political rhetoric surrounding tort reform but includes citations to resources with rhetorical analysis. *See, e.g.*, BAKER, *supra* note 14, at 10–14, 42–44 (explaining the politicization of malpractice reform); Hubbard, *supra* note 72; Kersch, *supra* note 42, at 43; John T. Nockleby & Shannon Curreri, *100 Years of Conflict: The Past and Future of Tort Retrenchment*, 38 LOY. L.A. L. REV. 1021 (2005) (viewing American tort reform efforts as a reflection of business and industry reactions to social, political, and economic forces in the United States).

88. *See, e.g.*, BAKER, *supra* note 14, at 70–87 (summarizing research on medical malpractice claim frequency and payment outcomes); SLOAN & CHEPKE, *supra* note 38, at 51–70 (explaining economic and behavioral impact of litigation and threatened litigation on providers); NEIL VIDMAR & VALERIE P. HANS, AMERICAN JURIES: THE VERDICT 321–38 (2007) (irrational jury awards have not caused the underlying problems with the medical malpractice system); Studdert et al., *Claims*, *supra* note 48, at 2024, 2032 (unmeritorious claims rarely succeed in litigation).

89. Bell, *supra* note 64, at 943, 943–49.

doctrine made it too easy to sue providers,⁹⁰ many states instituted a wide array of substantive and procedural reforms. For example, legislatures enacted statutes limiting *res ipsa loquitur* to only certain kinds of injuries—fault could be presumed when the wrong leg was amputated, for example, but not for misdiagnosis⁹¹—and establishing locality rules that tied standards of care to a particular geographic area rather than to a national standard.⁹² Other statutory reforms curbed malpractice liability payouts by restricting noneconomic and punitive damages⁹³ and by modifying rules on joint-and-several liability and collateral sources of compensation.⁹⁴

States also passed procedural reforms to limit claimants' access to courts. New laws shortened statutes of limitation and required injured patients to obtain a plaintiff's certificate of merit from a licensed attorney⁹⁵ or an affidavit, report, or certificate from an independent expert.⁹⁶ Included among these procedural reforms are statutes establishing ADR for medical malpractice claims. These ADR-based reforms constitute a specific and often overlooked subset of procedural reforms and are the focus of this Article.

II. LIMITING LITIGATION WITH ADR

As discussed in the previous Part, there are a number of fundamental problems with the conventional tort system. Unfortunately, state legislative reform efforts have been dominated by one primary objective: to make providers' liability insurance affordable by restricting the cost of medical malpractice litigation. To achieve this objective, lawmakers experimented with

90. There is evidence of more litigation in the mid-twentieth century due in part to changes in tort law that made it easier for plaintiffs to bring legal claims; for example, courts permitting wider use of *res ipsa loquitur* to establish evidence of negligence, the removal of governmental and charitable immunity from hospitals, and the abandonment of the locality rule for establishing standards of care. WEILER, *supra* note 20, at 19–26.

91. See, e.g., NEV. REV. STAT. § 41A.100 (2015); TEX. REV. CIV. PRAC. & REM. CODE ANN. Art. 4 § 74.201 (West 2015).

92. Michelle Huckaby Lewis et al., *The Locality Rule and the Physician's Dilemma: Local Medical Practices vs the National Standard of Care*, 297 JAMA 2633, 2635 (2007); WEILER, *supra* note 20, at 26–30.

93. See, e.g., MASS. GEN. LAWS ANN. ch. 231, § 60H (West 2016); NEV. REV. STAT. § 41A.035 (2015); TEX. REV. CIV. PRAC. & REM. CODE ANN. §§ 74.301–.303 (West 2015).

94. See, e.g., MASS. GEN. LAWS ANN. ch. 231, § 60G (2015); NEV. REV. STAT. § 41A.045 (2015). For a helpful summary of state reforms and studies assessing their effects, see CONG. BUDGET OFFICE, *THE EFFECTS OF TORT REFORM: EVIDENCE FROM THE STATES* (2004). The National Conference on State Legislatures maintains a relatively up-to-date database of state legislation relating to medical malpractice liability reform. *Medical Liability and Malpractice*, NAT'L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-and-malpractice.aspx> (last visited Oct. 21, 2016).

95. See, e.g., N.Y. C.P.L.R. § 3012-a (McKinney 2016); MISS. CODE ANN. § 11-1-58 (West 2016); FLA. STAT. ANN. § 766.104 (West 2008).

96. See, e.g., NEV. REV. STAT. § 41A.071 (2015); TEX. REV. CIV. PRAC. & REM. CODE ANN. § 74.351 (West 2013); W. VA. CODE ANN. § 55-7B-6 (West 2016).

a number of different ADR procedural interventions.⁹⁷ While many state courts have their own rules for ADR in civil cases, these statutes reflect a broader public policy commitment either to limit patients' access to the courts or to reduce their reliance on judicial intervention, or both.⁹⁸

Lawmakers institutionalized three different ADR interventions to make litigation less expensive and each process targeted a specific, problematic characteristic of malpractice litigation. Lawmakers concerned about "frivolous" or "unmeritorious" patient claims enacted legislation requiring plaintiffs to submit their claims to expert screening panels.⁹⁹ Legislators, convinced that lengthy, inexpert jury trials drove up litigation costs, passed statutes guiding parties to contract for binding arbitration and avoid court altogether.¹⁰⁰ More recently, lawmakers who viewed medical malpractice litigation as needlessly prolonged by parties' adversarial legalism¹⁰¹ promoted cooperative settlements by mandating parties to attend mediation.¹⁰² All three of these processes work to divert patients' legal claims out of the conventional tort system. They do not address the tort system's more profound structural problems, such as the large numbers of injured patients who never enter the system to receive compensation¹⁰³ and the broken informational feedback loop that, if fixed, would enable providers to learn from the past and prevent mistakes in the future.¹⁰⁴

97. Each successive ADR intervention followed a wave of insurance premium crises. See SLOAN & CHEPKE, *supra* note 38, at 28 (noting three periods of crisis in medical malpractice insurance: 1975–1978; 1984–1987; 2001–2004). Medical malpractice screening panel legislation was largely established in the 1970s, binding arbitration legislation came in the 1980s, and mandatory mediation legislation became more common in the 2000s.

98. Scholars debate whether such substance-specific procedures advance or hinder civil justice. See, e.g., Robert G. Bone, *Making Effective Rules: The Need for Procedure Theory*, 61 OKLA. L. REV. 319 (2008); Stephen N. Subrin, *Fudge Points and Thin Ice in Discovery Reform and the Case for Selective Substance-Specific Procedure*, 46 FLA. L. REV. 27 (1994). Setting aside that debate, it remains clear that these repeated procedural interventions reflect legislators' belief that malpractice cases require closer regulation and more tailored procedures than other types of claims, in effect creating medical malpractice "exceptionalism." Catherine Struve, *Doctors, the Adversary System, and Procedural Reform in Medical Liability Litigation*, 72 FORDHAM L. REV. 943, 1015 (2004).

99. See *infra* Part II.A and accompanying notes.

100. See *infra* Part II.B and accompanying notes.

101. ROBERT A. KAGAN, *ADVERSARIAL LEGALISM: THE AMERICAN WAY OF LAW* 3, 9 (2003). Professor Kagan defines "adversarial legalism" as "policymaking, policy implementation, and dispute resolution by means of lawyer-dominated litigation." *Id.* at 3. It has two characteristics: "formal legal contestation—competing interests and disputants readily invoke legal rights, duties, and procedural requirements, backed by recourse to formal law enforcement, strong legal penalties, litigation and/or judicial review" and "litigant activism—a style of legal contestation in which the assertion of claims, the search for controlling legal arguments, and the gathering and submission of evidence are dominated . . . by disputing parties or interests, acting primarily through lawyers." *Id.* at 9.

102. See *infra* Part II.C and accompanying notes.

103. See *supra* Part I.B.1.

104. See *supra* Part I.B.2.

The outcomes of these different ADR interventions vary in interesting ways. One common result for all three processes is that they do not lower providers' liability premiums. This conclusion should come as no surprise given the absence of a direct, causal connection between malpractice litigation costs and providers' insurance premiums.¹⁰⁵ Some studies do suggest, however, that when compared to court litigated outcomes, certain ADR processes may in fact help more injured patients receive compensation and, in select cases, for greater dollar amounts. Thus, taken together, these early ADR interventions did not achieve their intended effect of reducing providers' malpractice litigation costs; instead, they may have inadvertently helped some patients obtain better outcomes than they would have in court.

This Part analyzes the three ADR processes deployed by state legislatures since the beginning of the tort reform movement: legislation mandating medical screening panels, binding arbitration, and mediation. For each, the following issues are examined: 1) the structure of each ADR procedural intervention, including its operation, prevalence, statutory design, and impact on parties' substantive rights; 2) the policy rationale behind the ADR legislation; and 3) what empirical data reveal about the impact of the ADR process.

A. *The First Generation: Medical Screening Panels*

One of the earliest ADR procedural interventions deployed by state legislatures was the medical screening panel.¹⁰⁶ These panels were designed to serve as a procedural triage tent for medical malpractice claims, allowing experts to quickly assess the merits of legal claims.¹⁰⁷ The expectation was that a panel's finding of no liability would persuade a plaintiff to abandon a claim, whereas a panel that found liability would incentivize defendants to settle.¹⁰⁸ In either scenario, the panel process aimed to divert claims away from the courts and malpractice litigation.

States began passing screening panel statutes in the 1970s. Currently, seventeen jurisdictions utilize a screening process for medical malpractice

105. See *supra* note 88.

106. For an in-depth history of screening panels and their historical context, see Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. WASH. L. REV. 181 (1990), and Struve, *supra* note 98, at 948–75.

107. My use of “triage” here follows the medical definition: “the sorting of and allocation of treatment to patients . . . according to a system of priorities designed to maximize the number of survivors.” *Triage*, MERRIAM-WEBSTER DICTIONARY (11th ed. 2014). This is somewhat different than how the term has been used in other areas of legal scholarship to describe how administrative agencies can effectively sort cases. See, e.g., Matthew J.B. Lawrence, *Procedural Triage*, 84 FORDHAM L. REV. 79, 83 n.11 (2015).

108. Thomas B. Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 ALASKA L. REV. 429, 441 (1992).

claims, with panel structure and legal powers varying widely.¹⁰⁹ Panels usually consist of a licensed physician, practicing attorney, layperson, and, in cases brought against a hospital, a hospital administrator.¹¹⁰ Statutes often direct the panel to issue a report for the parties that examines the underlying facts of the case,¹¹¹ analyzes whether injuries sustained were caused by the medical practitioner's substandard care,¹¹² and, in some states, assesses the extent of the patient's injury and issues an appropriate dollar amount in compensation.¹¹³ Depending on the jurisdiction, appearing before a screening

109. These states include Alaska, Delaware, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Massachusetts, Montana, Nebraska, New Hampshire, New Mexico, Utah, Virginia, Wyoming, and the U.S. Virgin Islands. Heather Morton, *Medical Liability/Malpractice ADR and Screening Panels*, NAT'L CONFERENCE OF STATE LEGISLATURES (May 20, 2014), <http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-malpractice-adr-and-screening-panels-statutes.aspx> (providing an index of medical liability ADR and screening panel statutes and legislation). The terminology used to describe these panels varies too. They are sometimes called an "arbitration panel" or a "mediation panel," but function like screening panels. Compare MD. CODE ANN., CTS. & JUD. PROC. §§ 3-2A-01 to 3-2A-10 (West 2015) (using "arbitration panel"), with MICH. COMP. LAWS ANN. § 600.4901 to .4923 (West 2015) (using "mediation panel").

110. *E.g.*, HAW. REV. STAT. ANN. § 671-11(b) (LexisNexis 2015) ("Each medical inquiry and conciliation panel shall consist of one chairperson who shall be an attorney licensed to practice in the courts of the State and experienced in trial practice and the personal injury claims settlement process and one physician, osteopathic physician, or surgeon licensed to practice . . ."); IDAHO CODE ANN. § 6-1002 (West 2016) (requiring panels to include one lay person who is not a lawyer, doctor, or hospital employee and, for cases involving claims against a hospitals, one administrator at a state licensed acute care hospital).

111. *E.g.*, DEL. CODE ANN. tit. 18, § 6807 (2015) ("The evidence to be considered by the medical negligence review panel shall be promptly submitted . . . [and] may consist of medical charts, X-rays, laboratory tests, excerpts of treatises, depositions of witnesses including parties and any other form of evidence allowable by the medical negligence review panel."); IND. CODE ANN. § 34-18-10-22 (West 2016).

112. *E.g.*, ALASKA STAT. § 09.55.536 (2015). In Alaska, a panel must provide to the parties and the court detailed answers and explanations to the following questions:

- (1) Why did the claimant seek medical care?
- (2) Was a correct diagnosis made? If not, what was incorrect about the diagnosis?
- (3) Was the treatment or lack of treatment appropriate? If not, what was inappropriate about the treatment or lack of treatment?
- (4) Was the claimant injured during the course of evaluation or treatment or by failure to diagnose or treat?
- (5) If the answer to question 4 is "yes," what is the nature and extent of the medical injury?
- (6) What specifically caused the medical injury?
- (7) Was the medical injury caused by unskillful care? Explain.
- (8) If a medical injury had not occurred, what would have been the likely outcome of the medical case?

Id.

113. Jean Macchiaroli Eggen, *Medical Malpractice Screening Panels: An Update and Assessment*, 6 J. HEALTH & LIFE SCI. L. 1, 9 (2013).

panel could be a condition precedent to filing in court¹¹⁴ or an added procedural step after pleading but before discovery¹¹⁵—or could be waived altogether.¹¹⁶ In essence, these screening panels operate like informal and non-binding summary judgment, giving plaintiffs a red or green light to proceed forward with litigation.

The extent to which a panel's finding and its report impact parties' substantive claims varies across states. In some jurisdictions, panel reports remain confidential and inadmissible as evidence in any court action, although they could be forwarded to the provider's state professional licensing board.¹¹⁷ In other states, the panel serves as a "civil grand jury"¹¹⁸ or an expert tribunal with powers to subpoena witnesses¹¹⁹ and whose report is forwarded to the judge and becomes part of the court record.¹²⁰ Some states use the panel's finding as a carrot to entice settlement, for example, by deputizing screening panels to formalize settlement agreements and render them binding so parties can skip going to court for a final judgment and order.¹²¹ Conversely, the panel finding can become a stick that penalizes a plaintiff who chooses to continue with litigation after receiving an unfavorable panel review by, for example, requiring the plaintiff to post a bond for each named defendant in the continuing litigation.¹²²

114. *E.g.*, IND. CODE ANN. §§ 34-18-8-4 to 34-18-8-6 (West 2016) (requiring medical malpractice claims to go to a review panel before commencing court action unless the parties agree to waive the panel or the plaintiff seeks less than \$15,000 in damages); UTAH CODE ANN. § 78B-3-416(2) (LexisNexis 2015).

115. *E.g.*, VA. CODE ANN. §§ 8.01-581.2 to 581.3 (2015).

116. *E.g.*, LA. STAT. ANN. 40:1231.8(B)(1)(d) (2016).

117. *E.g.*, N.M. STAT. ANN. § 41-5-20(d) (LexisNexis 2015).

118. *E.g.*, IDAHO CODE § 6-1001 (2015).

119. *E.g.*, MASS. GEN. LAWS ANN. ch. 231, § 60B (West 2016) ("The tribunal may upon the application of either party or upon its own decision summon or subpoena any such records or individuals to substantiate or clarify any evidence which has been presented before it and may appoint an impartial and qualified physician or surgeon or other related professional person or expert to conduct any necessary professional or expert examination of the claimant or relevant evidentiary matter and to report or to testify as a witness thereto.").

120. *E.g.*, KAN. STAT. ANN. § 65-4904 (2015) ("(b) The screening panel shall notify all parties when its determination is to be handed down, and, within seven days of its decision, shall provide a copy of its opinion and any concurring or dissenting opinion to each party and each attorney of record and to the judge of the district court . . . (c) The written report of the screening panel shall be admissible in any subsequent legal proceeding . . .").

121. *E.g.*, MONT. CODE ANN. § 27-6-606(2) (West 2015) ("The panel may recommend an award, approve settlement agreements, and discuss the settlement agreements, all in a manner consistent with this part. All approved settlement agreements are binding on the parties.").

122. MICH. COMP. LAWS ANN. § 600.4915(2) (West 2015). The statute provides: "If the action proceeds to trial, the party who has been determined to have a frivolous action or defense shall post a cash or surety bond, approved by the court, in the amount of \$5,000.00 for each party against whom the action or defense was determined to be frivolous. If judgment is entered against the party who posted the bond, the bond shall be used to pay all reasonable costs incurred by the other parties and any costs allowed by law or by court rule, including court costs and reasonable attorney fees." *Id.*

Mandatory pre-litigation screening panels were supposed to diminish providers' liability premiums by correcting for two perceived problems: the high volume of lawsuits and high payouts resulting from judges' and jurors' lack of medical expertise. New Hampshire's medical screening statute offers an illustrative statement of legislative intent:

Availability and affordability of insurance against liability for medical injury is essential for the protection of patients as well as assuring availability of and access to essential medical and hospital care. This chapter affirms the intent of the general court to contain the costs of the medical injury reparations system and *to promote availability and affordability of insurance against liability for medical injury*. Claims for medical injury should be resolved as early and inexpensively as possible to contain system costs. Claims that are resolved before court determination cost less to resolve than claims that must be resolved by a court. Meritorious claims should be identified as quickly as possible, as should non-meritorious claims. Defendants should consider paying or compromising meritorious claims and plaintiffs should consider withdrawing or compromising non-meritorious claims, as soon as the merits of the claims are known to the parties. Presentation of claims to a medical review panel is intended to help identify both meritorious and non-meritorious claims without the delay and expense of a court trial. . . . The panel process will encourage the prompt resolution of claims, because both sides will be given an objective view of the merits. If the panel finds that a claim has merit, the defendant will be more likely to pay the claim or negotiate a compromise that is favorable to the claimant. If the panel finds that the claim lacks merit, the claimant is more likely to withdraw the claim or accept a nominal settlement.¹²³

In theory, screening panels would discourage "non-meritorious" claims and keep them out of courts, thereby reserving the court's time and resources to litigate valid claims.¹²⁴ Additionally, panels could encourage and facilitate an informed settlement of legally viable claims. And lastly, in those states where the panel's report entered the court record, they inserted an additional expert medical voice into legal proceedings, a voice not hired by one side or

123. N.H. REV. STAT. ANN. § 519-B:1 (2015) (emphasis added); *see also* Macchiaroli, *supra* note 106, at 186–87.

124. *See* WYO. STAT. ANN. § 9-2-1514 (2015) (stating that the purpose of the act is to prevent nonmeritorious claims against health care providers "where the facts do not permit at least a reasonable inference of malpractice," thus allowing "the fair and equitable disposition" of "well founded" claims).

the other, so that attorneys, judges, and lay jurors' analysis of whether negligence occurred might be further informed by medical expertise.¹²⁵

Despite these hoped-for reforms, the potential benefits of screening panels have not been borne out. Empirical studies of screening panels concluded that they have no systematic effect on the number of claims filed or paid,¹²⁶ nor do they reduce the cost or amount of time associated with litigating medical malpractice claims.¹²⁷ In fact, screening panels may increase the number of claims that proceed to litigation by reducing plaintiffs' costs of acquiring expert testimony.¹²⁸ Furthermore, they may not help lower parties' litigation expenses because most parties have to conduct discovery in preparation for the panel, thus shifting discovery costs from the litigation to the pre-litigation stage.¹²⁹ A backlog of cases waiting for a panel can also cause delays.¹³⁰ Another possible unintended consequence of screening panels is they may lead to *higher*, rather than reduced, malpractice liability premiums for providers. Panels screen out the claims that could have settled with a small payment and leave behind ambiguous claims that proceed to trial and necessitate greater expense.¹³¹

Screening panels also prompted numerous constitutional challenges.¹³² Opponents of screening panels successfully argued that requiring screening

125. Struve, *supra* note 98, at 988–89. In general, many providers sued for tortious negligence perceive the legal system as second-guessing their judgment as medical professionals and undermining their professional independence. WEILER, *supra* note 20, at 6. Indeed, when challenged on evidentiary grounds, courts uphold screening panel reports as additional expert testimony. Eggen, *supra* note 113, at 13–16.

126. Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW & CONTEMP. PROBS. 57, 72 (1986); Frank A. Sloan et al., *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 J. HEALTH POL. POL'Y & L. 663 (1989).

127. Frederick J. White III et al., *Medical Malpractice Review Panels and Medical Liability System Cost, Timeliness, and Efficiency: A Cross-Sectional Study*, 5 J. EMPIRICAL STUD. 375 (2008).

128. Danzon, *supra* note 126, at 72 (citing DANZON, *supra* note 44, at 198–202). Rather than having to hire and pay for their own expert witnesses, plaintiffs have the benefit of the panel's medical and legal experts for no, or low, cost. This translates into significant cost savings; even on the defense side, paying for experts constitutes anywhere from a quarter to almost a half of the total cost of defending a malpractice claim. Aaron E. Carroll et al., *The Impact of Defense Expenses in Medical Malpractice Claims*, 40 J.L. MED. & ETHICS 135, 140 (2012).

129. White III et al., *supra* note 127, at 377 (citing Catherine S. Meschievitz, *Efficacious or Precarious? Comments on the Processing and Resolution of Medical Malpractice Claims in the United States*, 3 ANNALS HEALTH L. 123, 136 (1994); Dennis J. Rasor, *Mandatory Medical Malpractice Screening Panels: A Need to Reevaluate*, 9 OHIO ST. J. ON DISP. RESOL. 115, 122 (1993)).

130. Nicole L. Kaufman, *The Demise of Medical Malpractice Screening Panels and Alternative Solutions Based on Trust and Honesty*, 28 J. LEGAL MED. 247, 256 (2007).

131. Sloan et al., *supra* note 126, at 677.

132. States where screening panel systems have been repealed or invalidated include Arizona, Illinois, Missouri, Nevada, New Jersey, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, and Wyoming. Catherine T. Struve, *Improving the Medical Malpractice Litigation Process*, 23 HEALTH AFF. 33, 35 n.8 (2004).

panels specifically for medical malpractice claims violates the Equal Protection Clause of the U.S. Constitution by impermissibly discriminating among different classes of legal claims.¹³³ In jurisdictions where the state constitution provides for an open and publicly available judiciary, critics of screening panels have argued, with mixed results, that panels create arbitrary delays and financial burdens that effectively block citizens' constitutional rights to access the courts.¹³⁴

Thus, from a reform standpoint, screening panels have not been a successful experiment. They did not fix the perceived problems of excessive litigation and providers' liability insurance costs and, while many statutes authorizing the panels remain on the books, they have largely fallen into disuse.¹³⁵ Furthermore, because screening panels operate within the frame of medical malpractice litigation, the fundamental problems with the conventional tort system go unaddressed. Screening panels have not been shown to help more injured patients receive compensation for their injuries, improve communication, or enable providers and patients to prevent future mistakes in medical treatment.

B. *The Second Generation: Binding Arbitration*

Binding arbitration presents another ADR process that state legislatures hoped would reduce medical malpractice litigation costs. Unlike medical screening panels, states do not statutorily compel parties to utilize binding arbitration¹³⁶; rather, the parties are supposed to elect, by private contract, to use binding arbitration.¹³⁷ However, states enacted legislation authorizing

133. Eggen, *supra* note 113, at 11 (discussing the 1983 decision of the Rhode Island Supreme Court in *Boucher v. Sayeed*, 459 A.2d 87, 93 (R.I. 1983), and the 1988 decision of the Wyoming Supreme Court in *Hoem v. State*, 756 P.2d 780, 783 (Wyo. 1988)).

134. *Id.* at 12 (citing *State ex rel. Cardinal Glennon Mem'l Hosp. for Children v. Gaertner*, 583 S.W.2d 107 (Mo. 1979) (holding that screening panels violate the state's constitution by imposing procedure as a precondition to access the courts)); *cf. State ex rel. Strykowski v. Wilkie*, 261 N.W.2d 434 (Wis. 1978) (finding that mandatory screening panels do not violate equal protection or due process nor do they constitute an unlawful delegation of judicial authority).

135. Jona Goldschmidt, *Where Have All the Panels Gone? A History of the Arizona Medical Liability Review Panel*, 23 ARIZ. ST. L.J. 1013 (1991). Most parties waive out of panels because plaintiff attorneys already screened their cases and think the case should proceed to litigation. *See, e.g., Bob Sanders, Questions Swirl Around Effectiveness of Medical Malpractice Panels*, N.H. BUS. REV. (Feb. 7, 2014) <http://www.nhbr.com/February-7-2014/Questions-swirl-around-effectiveness-of-medical-malpractice-panels/>.

136. *Cf.* 10 GUAM CODE ANN. § 10100–10147 (2015) (mandating binding arbitration for medical malpractice claims). Some states require courts to refer civil cases to non-binding arbitration as a case management and settlement tool. *See, e.g., HAW. REV. STAT. ANN.* § 601-20 (LexisNexis 2015).

137. Scholars often refer to this "private ordering" as "mandatory arbitration" to signal the lack of genuine, voluntary election by both parties to arbitrate. *See* Jaime Dodge, *The Limits of Procedural Private Ordering*, 97 VA. L. REV. 723, 728, 751 n.112 (2011) (courts increasingly enforce private contracts that defy fundamental norms of procedure); Melvin Aron Eisenberg, *Private Ordering Through Negotiation: Dispute-Settlement and Rulemaking*, 89 HARV. L. REV. 637 (1976).

providers and patients to contract for binding arbitration and, in a limited number of jurisdictions, attempted to regulate the enforceability of contract terms.¹³⁸

Binding arbitration operates like private adjudication. Unlike other forms of ADR, arbitration is not designed to induce voluntary settlement before trial but instead to side-step litigation altogether by vesting full decisionmaking power in private hands.¹³⁹ Arbitrators make decisions based on the facts presented by the parties and the legal merits of the case.¹⁴⁰ In the case of an alleged malpractice incident, an arbitrator determines whether or not a standard of care was met, assigns fault, and awards damages in compensation.¹⁴¹

Initially designed as a way for sophisticated parties to manage their business disputes quickly, arbitration allowed contracting parties to waive their right to trial and instead have their dispute decided by a private person, or panel of persons, from which there are limited rights to appeal.¹⁴² However, the application of arbitration has expanded dramatically over time, and the extent to which patients, and many other consumers, knowingly and voluntarily elect to arbitrate remains an open question.¹⁴³ In the medical context,

138. Irving Ladimer & Joel Solomon, *Medical Malpractice Arbitration: Laws, Programs, Cases*, 1977 INS. L.J. 335, 337–39.

139. Martin H. Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759, 768 (1977).

140. Kenneth A. DeVille, *The Jury is Out: Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims*, 28 J. LEGAL MED. 333, 333–39 (2007). Parties can agree on which procedures to use, for example how facts will be gathered and presented to the arbitrator, and which substantive law will govern the dispute. See, e.g., AM. HEALTH LAWYERS ASS'N DISPUTE RESOLUTION SERV., RULES OF PROCEDURE AND GUIDE TO ARBITRATION CLAUSES (2014), <https://www.healthlawyers.org/dr/Pages/default.aspx>.

141. Metzloff, *supra* note 71, at 204. Many arbitration agreements designate a private organization to handle the arbitration, such as the American Arbitration Association (“AAA”), National Arbitration Forum (“NAF”), Judicial Arbitration and Mediation Services (“JAMS”), or American Health Lawyers Association (“AHLA”), all of which have procedural rules and indicate which substantive and procedural law governs. DeVille, *supra* note 140, at 337–38; Ann H. Nevers, *Medical Malpractice Arbitration in the New Millennium: Much Ado About Nothing?*, 1 PEPP. DISP. RESOL. L.J. 45, 84–87 (2000).

142. Metzloff, *supra* note 71, at 204. In theory, parties can agree to use arbitration at any point along the evolution of the dispute, from before the dispute arises all the way to the moment before a jury trial. *Id.* at 204 n.5.

143. See, e.g., Linda J. Demaine & Deborah R. Hensler, “Volunteering” to Arbitrate Through Predispute Arbitration Clauses: *The Average Consumer’s Experience*, 67 LAW & CONTEMP. PROBS. 55 (2004); Jeff Sovern et al., “Whimsy Little Contracts” with Unexpected Consequences: *An Empirical Analysis of Consumer Understanding of Arbitration Agreements*, 75 MD. L. REV. 1 (2015). In late 2015, the New York Times published a three-part series on the prevalence of mandatory arbitration. Jessica Silver-Greenberg & Robert Gebeloff, *Arbitration Everywhere, Stacking the Deck of Justice*, N.Y. TIMES (Oct. 31, 2015), <http://www.nytimes.com/2015/11/01/business/dealbook/arbitration-everywhere-stacking-the-deck-of-justice.html>; Jessica Silver-Greenberg & Michael Corkery, *In Arbitration, a “Privatization of the Justice System”*, N.Y. TIMES (Nov. 1, 2015), <http://www.nytimes.com/2015/11/02/business/dealbook/in-arbitration-a-privatization-of-the-justice-system.html>; Michael Corkery & Jessica Silver-Greenberg, *In Religious Arbitration*,

some agreements to arbitrate are presented in the paperwork patients complete before seeing a provider, in hospital admission materials, or in the enrollment documents individuals receive when they sign up for health insurance.¹⁴⁴ Patients may not be aware that when they sign these documents, they are agreeing to arbitrate in the event they suffer an injury during treatment.

States enacted legislation promoting arbitration of malpractice claims and guiding parties on how to contract for this alternative to court litigation.¹⁴⁵ Some jurisdictions explicitly authorized parties to use arbitration for medical malpractice claims and provided guidance on how to draft arbitration clauses to ensure their enforceability.¹⁴⁶ Other state statutes directed malpractice defendants who are willing to concede liability to inform the plaintiff and then use arbitration to determine damages.¹⁴⁷

In other jurisdictions, statutes attempt to regulate binding arbitration contract formation. For example, some statutes refuse to enforce arbitration agreements signed as a precondition to receiving healthcare,¹⁴⁸ while other statutes only validate arbitration agreements signed after the dispute arose and in the presence of the patient's attorney.¹⁴⁹ States also attempt to control

Scripture is the Rule of Law, N.Y. TIMES (Nov. 2, 2015), <http://www.nytimes.com/2015/11/03/business/dealbook/in-religious-arbitration-scripture-is-the-rule-of-law.html>.

144. DeVille, *supra* note 140, at 333, 335; Elizabeth Rolph et al., *Arbitration Agreements in Health Care: Myths and Reality*, 60 LAW & CONTEMP. PROBS. 153, 154 (1997).

145. States shy away from directly mandating parties to binding arbitration because of constitutional due process concerns, an issue vigorously argued in the literature but that lies beyond the scope of this paper. *See generally*, HENRY COHEN, CONG. RESEARCH SERV., 92-228A, TORT REFORM: THE CONSTITUTIONALITY OF REQUIRING ALTERNATIVE DISPUTE RESOLUTION (1992); Jean R. Sternlight, *Rethinking the Constitutionality of the Supreme Court's Preference for Binding Arbitration: A Fresh Assessment of Jury Trial, Separation of Powers, and Due Process Concerns*, 72 TUL. L. REV. 1 (1997).

146. *See, e.g.*, CAL. CIV. PROC. CODE §§ 1281.9 to 1295 (West 2015); COLO. REV. STAT. ANN. § 13-64-403(1) (West 2016); S.D. CODIFIED LAWS § 21-25B-3 (2016). For an informative and much expanded discussion of California's approach to binding arbitration, see Rolph et al., *supra* note 144, at 161-68.

147. *See, e.g.*, N.Y. PUB. HEALTH LAW § 4406-a (MCKINNEY 2015); N.Y. C.P.L.R. § 3045 (McKinney 2015); FLA. STAT. ANN. § 766.106 (2015).

148. *See, e.g.*, 710 ILL. COMP. STAT. ANN. 15/8 (West 2016). These limits are likely preempted unless limited to insurance, where there is reverse preemption under the McCarran-Ferguson Act. Susan Randall, *Mandatory Arbitration in Insurance Disputes: Inverse Preemption of the Federal Arbitration Act*, 11 CONN. INS. L.J. 253, 264 (2005).

149. *See, e.g.*, GA. CODE ANN. § 9-9-62 (West 2015) ("However, no agreement to arbitrate shall be enforceable unless the agreement was made subsequent to the alleged malpractice and after a dispute or controversy has occurred and unless the claimant is represented by an attorney at law at the time the agreement is entered into."). For a discussion of Federal Arbitration Act preemption and the Georgia statute, see Ellwood F. Oakley, III, *The Next Generation of Medical Malpractice Dispute Resolution: Alternatives to Litigation*, 21 GA. ST. U. L. REV. 993, 994-99 (2005).

the process of privately contracted binding arbitration by mandating how discovery will be conducted,¹⁵⁰ which rules of evidence apply,¹⁵¹ and the amount arbitrators may award.¹⁵²

It remains unclear what motivates legislatures' efforts to regulate the time, place, and manner of medical malpractice arbitration contracts. Some statutes seem designed to protect arbitration agreements from challenge while others seem to reflect a desire to protect vulnerable consumers.¹⁵³ For example, a particular consumer protection concern is that patients are not well positioned to negotiate effectively with providers.¹⁵⁴ In fact, no real negotiation occurs, let alone knowing and voluntary agreement, if patients simply sign arbitration clauses included in the stack of paperwork requiring signature at the doctor's office or hospital.¹⁵⁵ Notwithstanding state efforts to rein in, or even guide, privately contracted binding arbitration agreements, these statutes likely would not hold up if challenged under federal preemption doctrine,¹⁵⁶ as states like Texas recently discovered.¹⁵⁷

150. See, e.g., 710 ILL. COMP. STAT. ANN. 15/11 (West 2016) (mandating parties with binding arbitration agreements to follow discovery rules in the Uniform Arbitration Act).

151. See, e.g., *id.* at 15/12 (mandating parties follow the state's rules of evidence in binding arbitration).

152. WASH. REV. CODE ANN. § 7.70A.060(2) (West 2015) (limiting arbitrators' awards to \$1 million in economic and noneconomic damages).

153. The tension between protecting individuals' liberty rights to contract freely, on one hand, and ensuring those contracts in fact advance societal values of justice and fairness, on the other hand, is baked into arbitration. For more discussion of this problem, see Richard C. Reuben, *Democracy and Dispute Resolution: The Problem of Arbitration*, 67 LAW & CONTEMP. PROBS. 279, 281 (2004) (analyzing arbitration through the lens of democracy theory).

154. Even among native English speakers, disparities in literacy between providers and patients pose a challenge, as basic healthcare materials are written above a tenth-grade level, whereas most adults read at eighth grade levels. Richard S. Safeer & Jann Keenan, *Health Literacy: The Gap Between Physicians and Patients*, 72 AM. FAM. PHYSICIAN 463, 463 (2005).

155. SLOAN & CHEPKE, *supra* note 38, at 310. Some states also tried to protect providers from being pressured to use arbitration contracts by their insurance liability providers. See, e.g., COLO. REV. STAT. ANN. § 13-64-403(1) (West 2016). Despite state efforts to ensure binding arbitration agreements are not contracts of adhesion for any party, the likelihood that such restrictions will hold up under current federal preemption analysis appears unlikely. For an analysis of U.S. Supreme Court doctrine governing Federal Arbitration Act preemption, see Christopher R. Drahozal, *Federal Arbitration Act Preemption*, 79 IND. L.J. 393 (2004). For an expanded discussion of ADR and contracts of adhesion, see Stephan Landsman, *ADR and the Cost of Compulsion*, 57 STAN. L. REV. 1593 (2005).

156. Jean R. Sternlight, *Panacea or Corporate Tool?: Debunking the Supreme Court's Preference for Binding Arbitration*, 74 WASH. U. L.Q. 637, 660-74 (1996); see also *Doctor's Assocs., Inc. v. Casarotto*, 517 U.S. 681 (1996) (holding that a Montana state law invalidating any arbitration agreement that did not have an all-caps and underlined notice on the first page of the contract as inconsonant with the Federal Arbitration Act because it only targets arbitration clauses and not all contracts and is therefore preempted by the federal law); Stephen J. Ware, *Arbitration and Unconscionability After Doctor's Associates, Inc. v. Casarotto*, 31 WAKE FOREST L. REV. 1001 (1996).

157. *Fredericksburg Care Co., L.P. v. Perez*, 461 S.W.3d 513 (Tex. 2014) (holding that the FAA preempted Texas state law setting out format and notice requirements for patient-provider arbitration agreements (citing TEX. CIV. PRAC. & REM. CODE ANN. § 74.451 (West 2015))).

The policy rationale behind authorizing binding arbitration of medical malpractice disputes mirrors that of screening panels yet, also similar to screening panels, a subsequent reduction in liability costs has not been borne out in practice. Legislators hoped that diverting malpractice cases away from litigation and instead to private arbitral adjudication would, in theory, reduce parties' expenditures of time and money, employ decisionmakers with greater subject-matter expertise than judges and juries, and provide privacy to patients and providers.¹⁵⁸

But empirical studies of outcomes in private, binding arbitration indicate that it has not resulted in the intended effect legislators hoped for: greater efficiency and reduced medical liability system costs. For example, one study found that, contrary to the intended outcome, medical malpractice insurance premiums went *up*, not down, in jurisdictions with statutes permitting binding arbitration of claims.¹⁵⁹ Another study found that laws permitting binding arbitration correlated with an increase in the frequency of medical malpractice claims, both filed and paid out, particularly for small claims that likely would not be brought to court due to the prohibitive cost of court litigation.¹⁶⁰ A third study comparing outcomes of litigated and arbitrated claims found that patients who suffered permanent disabilities prevailed more frequently in arbitration than in litigation and that damages awards for permanent disabilities were higher in arbitration than in litigation.¹⁶¹ Thus, total liability costs appear to increase with arbitration, although the payouts are spread among a greater number of claims.¹⁶²

Despite these outcomes, maybe even because of them, binding arbitration of medical malpractice claims is not widespread. Providers may perceive that greater payouts lead to higher liability costs and, perhaps as a consequence, do not widely use binding arbitration clauses in healthcare

158. Metzloff, *supra* note 71, at 208–10 (noting that litigation expenses often exceed compensation paid to injured patients); DeVille, *supra* note 140, at 340 (attributing costs savings to expedited hearing schedules, truncated and limited scope of discovery, and less formal evidentiary rules); Ladimer & Solomon, *supra* note 138, at 353 (citing survey results from R.L. Peck, *Binding Malpractice Arbitration: Most Doctors Are for It*, MED. ECON. (Apr. 4, 1977)).

159. Frank A. Sloan, *State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment*, 9 J. HEALTH POL. POL'Y & L. 629, 636, 639–40 (1985); see also Stephen Zuckerman et al., *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167, 176 (1990) (finding that procedural tort reforms, such as mandatory screening panels or encouragement of binding arbitration, had no significant effect on providers' malpractice liability premiums with the exception of obstetric/gynecologic specialists).

160. Danzon, *supra* note 126, at 72. A study of malpractice claims in Florida between 1990 and 2008 found that arbitration was used to resolve cases with less severe injuries that often involved issues of monitoring and diagnosis. Mirya Holman et al., *Most Claims Settle: Implications for Alternative Dispute Resolution from a Profile of Medical-Malpractice Claims in Florida*, 74 LAW & CONTEMP. PROBS. 103, 120–22 (2011).

161. WEILER, *supra* note 20, at 102 (citing Irving Ladimer et al., *Experience in Medical Malpractice Arbitration*, 2 J. LEGAL MED. 433 (1981)).

162. Danzon, *supra* note 126, at 77.

contracts.¹⁶³ While some patients may fare better in arbitration than in traditional tort litigation, uncertainty continues about whether arbitration undermines consumer protection in the healthcare context.¹⁶⁴ Critics further argue that arbitration perpetuates the same problems inherent to litigation—cost, adversarialism, the evidentiary challenges of proving fault—just in a different setting.¹⁶⁵

C. *The Third Generation: Mediation*

Mandatory mediation is the third generation of ADR procedural interventions deployed to reform the medical malpractice system.¹⁶⁶ In mandating parties to attend mediation, some policymakers hoped mediation would help focus settlement discussions, make them better informed and more efficient, and ultimately lead to out-of-court resolution of medical malpractice claims.¹⁶⁷ In contrast to earlier ADR interventions, mediation offers the first

163. Elizabeth S. Rolph et al., *Arbitration Agreements in Healthcare: Myths and Reality*, 60 LAW & CONTEMP. PROB. 153, 171 (1997); Edward A. Dauer, *Postscript on Health Care Dispute Resolution: Conflict Management and the Role of Culture*, 21 GA. ST. U. L. REV. 1029, 1036–37 (2005) (reporting on the surprisingly low number of malpractice cases that actually go to arbitration). Managed care organizations like Kaiser Permanente require arbitration for all malpractice claims, although its program has not gone without challenge. For discussion and analysis, see Alan B. Morrison, *Can Mandatory Arbitration of Medical Malpractice Claims Be Fair? The Kaiser Permanente System*, 70 DISP. RESOL. J. 35, 59 (2015), and Gary T. Schwartz, *Medical Malpractice, Tort, Contract, and Managed Care*, 1998 U. ILL. L. REV. 885, 903, 905–07.

164. Deville, *supra* note 140, at 366–74; Metzloff, *supra* note 71, at 210–21. Pre-dispute binding arbitration has a number of built-in characteristics that advantage defendant providers and disadvantage patients: patients may not understand what they are agreeing to when they sign arbitration agreements; they may not be able to secure legal representation for arbitration and therefore have to make their own case against repeat player defense attorneys; they have to cover arbitration fees up front; and they face an abbreviated discovery process that may make it harder to prove their claim and a limited right of appeal. *Id.*

165. Metzloff, *supra* note 71, at 215–16.

166. Mediation or some form of facilitated settlement process is required by statute for medical malpractice claims in Connecticut, the District of Columbia, Florida, Kansas, Nevada, New York, Oregon, South Carolina, and Washington. Vermont statute sets out a procedure for pre-suit mediation but does not make participation mandatory. Excluded from this list are screening panel programs like those in Michigan that are confusingly called “mediation.” A statutory mandate is not required for mediation, however, and many jurisdictions also send civil claims to mediation pursuant to court rules. Morton, *supra* note 109.

167. The reason for requiring mediation for malpractice cases in Connecticut was “litigation avoidance.” *An Act Concerning Adverse Events at Hospitals and Out Patient Surgical Facilities, Discussion of Senate Amendment Schedule B to S.B. 248*, 2010 Gen. Assemb., Feb. Sess. (Conn. May 1, 2010) (statement of Sen. Andrew J. McDonald) (“One of the things that we have been trying to encourage in this state is litigation avoidance strategies . . . this [law] will be yet another effort in our ongoing efforts to alleviate or reduce the amount of needless litigation, particularly in the area of medical malpractice.”). For a discussion of mediation as a forum for legal negotiations, see Craig A. McEwen et al., *Bring in the Lawyers: Challenging the Dominant Approaches to Ensuring Fairness in Divorce Mediation*, 79 MINN. L. REV. 1317, 1379–85 (1995); Robert A. Baruch Bush, *What Do We Need a Mediator For?: Mediation’s “Value-Added” for Negotiators*, 12 OHIO ST. J. DISP. RESOL. 1 (1996).

procedural reform aimed to address the communication barriers between providers and patients as a secondary objective after reducing litigation costs.

As an ADR process, mediation is fundamentally different from both screening panels and binding arbitration. In the medical malpractice litigation setting, mediation usually unfolds as an informal, confidential settlement negotiation. The parties and their lawyers engage in settlement discussions facilitated by a neutral third-party mediator.¹⁶⁸ Although participation may be mandatory, agreeing to settle the case is voluntary; the parties themselves determine the terms of a settlement agreement and choose to be bound it. Typically, the confidentiality of mediation discussions makes them inadmissible in any future court proceedings.

Statutes mandating medical malpractice mediation sometimes include specific instructions to encourage settlement. For example, some jurisdictions mandate mediation as a condition precedent to filing a claim in court, often in conjunction with laws requiring specialized notice and informal discovery requirements.¹⁶⁹ Other jurisdictions mandate mediation after filing but before formal discovery or trial.¹⁷⁰ State statutes may also instruct parties to submit statements to the mediator explaining the issues in the case, the parties' positions, and information that would narrow the scope of the dispute before the mediation occurs.¹⁷¹

Thus, mandatory mediation in the medical liability context imposes a less indelible impact on parties' substantive claims than screening panels and binding arbitration. While some mediators may recommend a settlement, suggest a settlement amount, or evaluate the strength of parties' legal positions,¹⁷² the mediator has no legal authority to impose a decision on parties or to give the plaintiff a green light to proceed with litigation.¹⁷³ If any claim is settled in mediation, parties must mutually agree not only to the content of settlement terms, but also to be bound by them.

168. Mediation is a flexible process and looks very different based on its context. Lydia Nussbaum, *Mediation as Regulation: Expanding State Governance Over Private Disputes*, 2016 UTAH L. REV. 361. For a description of how medical malpractice cases are conducted in one jurisdiction, see Ralph Peeples et al., *Following the Script: An Empirical Analysis of Court-Ordered Mediation of Medical Malpractice Cases*, 2007 J. DISP. RESOL. 101, and Thomas B. Metzloff et al., *Empirical Perspectives on Mediation and Malpractice*, 60 LAW & CONTEMP. PROBS. 107 (1997).

169. See, e.g., S.C. CODE ANN. §§ 15-79-120, 15-79-125 (2015); FLA. STAT. § 766.106 (2016). For an expanded discussion of Florida's multi-tiered sequence of ADR processes for malpractice claims, see Holman et al., *supra* note 160, at 103, 106-07.

170. See, e.g., CONN. GEN. STAT. § 52-190c (2016); WASH. REV. CODE ANN. § 7.70.100 (West 2013).

171. See, e.g., D.C. CODE § 16-2825 (2016); VT. STAT. ANN. tit. 12, § 7012(c) (West 2015).

172. Metzloff et al., *supra* note 168, at 121-23.

173. This is true even in jurisdictions that enable, or require, the judge overseeing the case to be the mediator. See, e.g., CONN. GEN. STAT. § 52-190c(c).

The policy rationale for mandating mediation of medical malpractice claims is to enable settlement of claims with limited court involvement,¹⁷⁴ an objective not unique to medical malpractice cases alone.¹⁷⁵ Mediation is inexpensive for courts because parties usually bear the cost of the mediator. Mediation also requires fewer court administrative resources than other forms of ADR, such as screening panels.¹⁷⁶ Attaching pre-suit notice and informal discovery requirements to the mediation process can help correct information asymmetry problems, which are particularly acute in medical malpractice cases, and lead to more informed settlement discussions.¹⁷⁷ In addition, and in notable contrast to previous generations of ADR that depended on litigation to provide information, advocates of mediation in the medical malpractice context posit that mediation now enables injured patients and their families to obtain a more detailed explanation of what went wrong, and why.¹⁷⁸ Mediation creates a confidential forum for the defendant to offer an apology¹⁷⁹ or make benevolent gestures without fear these actions will later be used in court.¹⁸⁰

Despite the potential for mediation to serve as a “safe harbor with therapeutic potential . . . to address the source as well as the consequence” of the

174. Phil Mendelson, Chairman of the Committee on the Judiciary for the District of Columbia, explained that the Medical Malpractice Reform Act of 2006, which includes mandatory pre-file mediation and the inadmissibility of certain benevolent gestures, was designed to:

[E]ncourage early settlements and facilitate the parties’ ability to reach a settlement. Settlements, especially ones accomplished early in the litigation process, lower each party’s individual costs (providing cost savings that can be spread to the general public through less costly insurance rates), and promote judicial economy by decreasing the time and money spent by the court on these complicated and contentious issues A statement of public policy that honest and open communication between the parties will diffuse the adversarial environment oftentimes resorted to in today’s litigious society.

PHIL MENDELSON, COUNCIL OF D.C. COMM. ON JUDICIARY, REPORT ON BILL 16-418, THE “MEDICAL MALPRACTICE REFORM ACT OF 2006,” 1–2 (2006).

175. *See, e.g.*, ANDREW I. SCHEPARD, CHILDREN, COURTS, AND CUSTODY: INTERDISCIPLINARY MODELS FOR DIVORCING FAMILIES 50–67 (2004).

176. Metzloff et al., *supra* note 168, at 109.

177. Frank A. Sloan & Thomas J. Hoerger, *Uncertainty, Information and Resolution of Medical Malpractice Disputes*, 4 J. RISK & UNCERTAINTY 403, 404 (1991).

178. Chris Stern Hyman et al., *Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?*, 35 J. HEALTH POL. POL’Y & L. 797, 800–01 (2010); Eric Galton, *Mediation of Medical Negligence Claims*, 28 CAP. U. L. REV. 321 (2000) (noting that mediation can “heal” the dysfunctional communication common in medical negligence lawsuits, giving parties opportunities to express regret, gain closure, and restore a previously valued relationship).

179. Ellen Deason, *The Quest for Uniformity in Mediation Confidentiality: Foolish Consistency or Crucial Predictability*, 85 MARQ. L. REV. 79, 80–81 (2001) (stating that confidentiality in mediation enables free and “forthright” communication between adversaries by, among other things, eliminating the fear that such communications will be used in future litigation).

180. For example, the District of Columbia established its mandatory mediation requirement for medical malpractice claims, D.C. CODE ANN. § 16-2821 (West 2017), as a portion of a larger Medical Malpractice Amendment Act, 2006 D.C. Sess. Law. Serv. 16-263 (West), which also rendered “benevolent gestures” made by a provider to a victim, or victim’s family, inadmissible as evidence of admission of liability. D.C. CODE ANN. § 16-2841 (West 2017).

patient's claim,¹⁸¹ the model of mediation most frequently employed may not realize this potential. In practice, medical negligence mediations focus primarily on the financial element of the case, employing a "single-axis, conventional negotiation over the settlement amount,"¹⁸² rather than also addressing non-monetary interests.¹⁸³ And, there may not be an opportunity for a meaningful apology between the parties, as providers may not attend settlement negotiations themselves.¹⁸⁴ Nonparticipation by the provider undermines the additional benefits that can come from direct communication:

When defendant physicians do not participate in mediations, those physicians, the defendant hospitals, the plaintiff patients and families, and the general population of patients all lose. Non-participation of defendant physicians leads to a loss of the opportunity for patients and physicians to reconcile, loss of the opportunity for the physician to be forgiven and for the patient or family to forgive, loss of the opportunity for the physician and family members to forgive themselves, loss of the opportunity for information giving and gathering, and loss of the opportunity to consider changes in institutional policies and practices.¹⁸⁵

Although mediation advocates identify many benefits from using mediation to address patient injuries, empirically demonstrating a direct impact of mandatory mediation on malpractice litigation costs proves elusive. Researchers studying mediation of malpractice claims note that some cases settle during the mediation session but many others settle later or are dropped by the plaintiff.¹⁸⁶ However, it is difficult to know whether a case ultimately settled *because* of information exchanged in the mediation or whether the

181. Dauer & Marcus, *supra* note 58, at 199.

182. Dauer, *supra* note 163, at 1037.

183. Galton, *supra* note 178, at 324 (noting that lawyer-mediators often feel pressured to exclude non-monetary issues and to focus only on the financial negotiation that will settle the case).

184. See Carol B. Liebman, *Medical Malpractice Mediation: Benefits Gained, Opportunities Lost*, 74 LAW & CONTEMP. PROBS. 135, 136–38 (2011) (describing two studies of medical malpractice mediation in which not a single physician participated in the mediations); Jennifer K. Robbennolt, *The Effects of Negotiated and Delegated Apologies in Settlement Negotiation*, 37 LAW & HUM. BEHAV. 128, 129–31 (2013) (noting that the results of an empirical study found that apologies given in the civil litigation setting were less effective when delivered by an attorney on behalf of a wrongdoer than when delivered directly by the wrongdoer). For a discussion of the psychology surrounding apology in torts, see generally Jennifer K. Robbennolt, *Apologies and Reasonableness: Some Implications of Psychology for Torts*, 59 DEPAUL L. REV. 489 (2010).

185. *Id.* at 140–41.

186. Metzloff et al., *supra* note 168, at 134–35 (finding that of 202 cases actually mediated during a two year period, only 50 cases were fully or partially resolved at the mediation itself, 45 were subsequently tried, 6 were resolved by summary judgment or motions to dismiss, 68 were settled or voluntarily dismissed, 23 were dropped by the plaintiff, and 10 were still pending before conclusion of the study).

mediation served as just one step in a larger settlement process.¹⁸⁷ Given the challenge of knowing how responsible a mediation session was for a subsequent settlement, it remains unknown how the frequency of mediated settlements and parties' costs compare to litigation outcomes.

Some lessons can be gleaned, however, from the experience of hospital systems with their own, private in-house mediation programs. These hospitals report that, in comparison to traditional litigation, mediated claims were resolved faster, considerably lowered providers' legal expenses, and allowed claimants to retain a greater percentage of the settlements paid due to reduced attorneys' fees.¹⁸⁸ However, the reduction in time and cost could be because the hospital programs are used for cases in which the provider takes responsibility for the incident up front, rendering the mediation a negotiation over compensation rather than an argument over proving liability.¹⁸⁹

* * *

Lawmakers used ADR legislation to alter the process of malpractice litigation based upon the mistaken belief that reducing malpractice litigation costs would decrease providers' liability insurance premiums. These experiments with ADR procedural interventions had little-to-no proven effect on liability insurance premiums. One reason ADR procedural reforms failed to have their intended impact is because policymakers misidentified unmeritorious claims and irrational jury awards as the underlying problems with the medical malpractice system.¹⁹⁰ While the incidence of malpractice litigation has decreased since the 1970s,¹⁹¹ studies indicate that limits on damages, not new ADR procedures, are primarily responsible.¹⁹²

187. Holman et al., *supra* note 160, at 132; Metzloff et al., *supra* note 168, at 135–39; Peebles et al., *supra* note 168, at 117.

188. Randall C. Jenkins et al., *Mandatory Presuit Mediation: 5-Year Results of a Medical Malpractice Resolution Program*, 33 J. HEALTHCARE RISK MGMT. 15 (2014) (reporting that a study of a mandatory mediation program used in University of Florida Health System hospitals showed that, compared to litigation, claims were resolved eighty-one percent faster, providers' health costs were ninety percent lower, claimants retained thirty-four percent more of the settlement amount). Chicago's Rush-Presbyterian-St. Luke's Medical Center began a voluntary mediation program in 1995 and found similar benefits: ninety percent of claims settle and, compared to litigation, defense costs were reduced by more than half. Max Douglas Brown, *Rush Model Can Allow Risk Managers to Control Litigation Costs*, 22 J. HEALTHCARE RISK MGMT. 19 (2002).

189. Dauer, *supra* note 163, at 1037.

190. These causes have been debunked by social scientists and economists. See VIDMAR & HANS, *supra* note 88, at 321–38; Studdert et al., *Claims*, *supra* note 48, at 2024, 2032.

191. CYNTHIA G. LEE & ROBERT C. LAFOUNTAIN, NAT'L CTR. FOR STATE COURTS, *MEDICAL MALPRACTICE LITIGATION IN STATE COURTS* 1, 5 (2011) (finding that medical malpractice lawsuits are uncommon, juries decide against plaintiffs more than seventy-five percent of the time, and damages are proportionate to severity of injury).

192. SLOAN & CHEPKE, *supra* note 38, at 104–05 (“After three decades of experience with state tort reform and evaluations covering a period almost as long, the key finding is that only damage caps have consistently affected various outcomes of interest, including claim frequency and severity, medical malpractice premiums, and physician supply.”).

These early ADR interventions did not target the profound flaws in the tort system itself, discussed in Part I, such as the significant numbers of patients burdened with the cost of healthcare injuries, poor communication between patients and providers, and ineffective deterrence of healthcare mistakes. Medical screening panels address none of these problems inherent to the tort system. Although empirical evidence suggests that binding arbitration may have the modest effect of helping more injured patients receive compensation than they would in court litigation, the process still requires patients first to know enough to bring a tort claim and then to prove negligence. And while mediation can provide an opportunity for parties to talk to one another confidentially, the potential benefits are undermined by party nonparticipation and adversarial discussions focused on proving fault.¹⁹³ Thus, because these ADR processes all work within the flawed tort litigation framework, previous state legislative experiments with ADR have not yielded positive substantive reforms. A new ADR experiment, however, attempts to construct a process that uses neither the legal norms nor the adversarial process of the conventional tort system.

III. USING ADR TO IMPLEMENT NEW REFORM OBJECTIVES: TRANSPARENCY & COMMUNICATION

The shortcomings of previous ADR experiments have not deterred policymakers. To the contrary, even more radical experimentation with ADR as a reform tool has emerged in the past decade. Instead of the earlier “malpractice insurance crisis” narrative, with its mission to curb litigation and restrict patients’ access to courts, the latest ADR reform efforts emphasize a different goal: improving patient safety.¹⁹⁴ These new ADR processes, referred to collectively as Communication and Resolution Programs (“CRPs”), attempt to change how patients and providers interact after an adverse health incident. CRPs prioritize transparency over secrecy with a focus on preventing system errors rather than finding individual fault.¹⁹⁵ They seek to include, rather than exclude, all parties impacted by a medical injury, thereby positioning parties as collaborators rather than adversaries. This approach is

193. Dauer, *supra* note 37, at 300–05 (explaining that mediation could allow broader discussions than the “‘only-money-or-no-money’ remedy” of tort liability and improve the malpractice system’s deterrence feedback loop but it would require overcoming significant institutional obstacles).

194. Studdert et al., *supra* note 85, at 283, 287 (discussing the two conflicting cultures of malpractice law and patient safety).

195. CRPs derive largely from a process used by hospital risk management units. Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANN. INTERN. MED. 963, 963 (1999) (“[R]isk management usually refers to self-protective activities meant to prevent real or potential threats of financial loss due to accident, injury, or medical malpractice.”). The earliest CRPs were used in veterans’ hospitals, most notably the Veterans Affairs Medical Center at Lexington, Kentucky, which began its program in 1987. *Id.* at 964.

unique because it has the potential to address problems inherent to the tort system in ways that previous generations of ADR did not. Reform advocates hope these new processes will address the problems of uncompensated patient injuries, poor communication between patients and providers, and the missed opportunities to deter future medical mistakes.¹⁹⁶

This Part explains the history and goals of the patient safety movement and then contrasts a corrective justice model inspired by patient safety norms with the traditional tort-based malpractice system. It then discusses the important role ADR plays in operationalizing the alternative corrective justice model envisioned by the patient safety movement.

A. *The Patient Safety Movement*

Despite the power of modern medicine to cure disease and prolong life, those powers remain constrained by human fallibility. A significant number of people in the United States suffer serious injury and death from mistakes made during the course of their medical treatment.¹⁹⁷ While this information was available for decades, it went unappreciated in mainstream medical malpractice reform debates until the IOM released its disconcerting 1999 report describing widespread errors in medical care, *To Err Is Human*.¹⁹⁸

To Err Is Human brought into sharp relief key problems in the healthcare delivery system. Drawing on the studies of medical injury rates and malpractice claims discussed earlier,¹⁹⁹ the report pronounced medical errors a leading cause of death and injury in the United States and estimated these errors cost tens of billions of dollars annually.²⁰⁰ The IOM reported that between 44,000 and 98,000 people die each year from preventable medical errors, an estimate that subsequent studies have shown to be far too low.²⁰¹ The report issued a call to action, denouncing the status quo as unacceptable, unethical, and intolerable, and outlined a series of recommendations

196. See *infra* Parts III.A–III.B.

197. See *supra* notes 1–3 and accompanying text.

198. INST. OF MED., *supra* note 1. *To Err is Human* found the incidence of preventable errors in medical care was much higher than generally accepted—and even it relied on outdated statistics. For history and context of the report, see Mello & Brennan, *supra* note 12, at 1595–96. For an analysis of how the rhetoric of medical malpractice changed after publication of the IOM report, see Henry Thomas Stelfox et al., *The “To Err Is Human” Report and the Patient Safety Literature*, 15 QUALITY & SAFETY IN HEALTHCARE 174 (2006).

199. See *supra* Part I.B.1 and accompanying notes.

200. INST. OF MED., *supra* note 1, at 26, 40–42.

201. Part of what was shocking about the IOM’s estimate was that it placed death from preventable medical injury above other, more recognized causes of death, such as motor vehicle accidents, breast cancer, and AIDS. *Id.* at 26 (citing CDC vital statistics). More recent empirical data indicate even higher numbers of preventable injuries and deaths. See Brennan et al., *supra* note 44; Leape et al., *supra* note 44; Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 MED. CARE 261 (2000) (discussing the 1984 Harvard Medical Practice Study and the 1992 Colorado and Utah study); see also *supra* notes 2–3.

to enable providers to learn from errors and ultimately improve patient safety.²⁰²

After the IOM issued this report, voices in the medical malpractice reform debate began asking how best to prevent errors in the healthcare delivery system and improve the quality of healthcare.²⁰³ Many scholars, providers, and policymakers embraced this movement, often termed the “patient safety movement,” in calling for a complete reimagining of the medical malpractice system.²⁰⁴ Even then-Senators Hillary Rodham Clinton and Barack Obama co-authored a bill in 2006 to address the inadequacy of the tort system for preventing medical errors and compensating injured patients.²⁰⁵ They pointed out that the current medical malpractice regime “jeopardizes patient safety by creating an intimidating liability environment,” and called for a new system of disclosure and early communication that would address preventable medical injuries and provide patients compensation in a less adversarial manner.²⁰⁶ Today, even the American Medical Association, long an advocate of the earlier reform policies designed to limit malpractice litigation, supports exploring alternatives to tort litigation.²⁰⁷ Thus, the revelations of the patient safety movement spurred new approaches to medical liability reform and a search for dispute resolution models to deliver these reforms.²⁰⁸ And, yet

202. INST. OF MED., *supra* note 1, at 3–4.

203. William M. Sage, *Malpractice Reform as a Health Policy Problem*, in MEDICAL MALPRACTICE AND THE U.S. HEALTHCARE SYSTEM, *supra* note 36, at 31, 31–33.

204. Lucian L. Leape, *Scope of Problem and History of Patient Safety*, 35 OBSTETRICS & GYNECOLOGY CLINICS OF N. AM. 1, 3–5 (2008) (describing the history of the patient safety movement, including influential organizations, studies, and reports); Robert M. Wachter, *Patient Safety at Ten: Unmistakable Progress, Troubling Gaps*, 29 HEALTH AFF. 165 (2010) (explaining how the scope of the patient safety movement has broadened since it began). The Patient Safety has also gone global, with the World Health Organization’s “World Alliance for Patient Safety.” *World Alliance for Patient Safety*, WORLD HEALTH ORG., <http://www.who.int/patientsafety/worldalliance/en/> (last visited Dec. 28, 2016).

205. National Medical Error Disclosure and Compensation Act, S. 1784, 109th Cong. (2005) (also referred to as the “National MEDiC Act”).

206. Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 NEW ENG. J. MED. 2205, 2206–08 (2006).

207. AM. MED. ASS’N, ADVOCACY RESOURCE CENTER, EARLY DISCLOSURE AND COMPENSATION PROGRAMS 1 (2015).

208. For example, there is an entire field of “Dispute System Design” devoted to studying how conflicts, disputes, issues of concern, and legal cases are (or ought to be) identified and raised, defined and labeled, and processed and ignored within “the context of a system of rules, processes, steps, and forums” in both public and private sectors. Lisa Blomgren Bingham, *Designing Justice: Legal Institutions and Other Systems for Managing Conflict*, 24 OH. ST. J. DISP. RESOL. 1, 2 (2008); see also CATHY A. COSTANTINO & CHRISTINA SICKLES MERCHANT, DESIGNING CONFLICT MANAGEMENT SYSTEMS: A GUIDE TO CREATING PRODUCTIVE AND HEALTHY ORGANIZATIONS (1996); Stephanie Smith & Janet Martinez, *An Analytic Framework for Dispute Systems Design*, 14 HARV. NEGOT. L. REV. 123, 124–25 (2009). How to design an ideal alternative to the tort system is an important question but lies beyond the scope of this Article, which instead focuses on the relationship between policy reform objectives and the dispute systems chosen by policymakers to deliver them.

again, ADR provides the means for testing how these reform objectives can be achieved.

B. A Dispute Resolution Model Where Negligence Doesn't Rule

The patient safety paradigm's emphasis on healthcare delivery systems and non-adversarial problem-solving contrasts sharply with the conventional tort system and necessitates an alternative model of corrective justice.

Consider, first, the patient safety movement's focus on system failures as opposed to individual failures. The tort negligence model requires demonstrating that an individual's failure to perform at a reasonable standard caused harm to someone else. But the IOM report and subsequent patient safety literature blames the fragmented and decentralized healthcare delivery system itself, rather than individual bad actors, for treatment errors that harm patients.²⁰⁹ The healthcare delivery system is characterized as a system of interdependent human and nonhuman elements.²¹⁰ For example, intravenous delivery of medication during surgery can involve automated equipment and a number of different people—nurses, anesthesiologists, and bioengineering staff—to set-up, program, and monitor drug infusion during the procedure.²¹¹ Under the IOM's "system" analysis, potential errors might occur because of "the equipment, the people, their interactions with each other and with the equipment, the procedures in place, and the physical design of the surgical suite in which the equipment and people function."²¹² Thus, negligence provides a poor fit for addressing errors in this system context because individuals' single, isolated, unreasonable acts may not be a proximate or actual causes of the harm.

Next, consider the patient safety movement's call for open and transparent communication in order to help injured patients and prevent system errors from reoccurring. In the conventional tort system, the adversarialism of litigation threatens communication between doctors and patients and can lead to the "bristling" and "cloaking" behaviors discussed earlier.²¹³ Without discussion of medical injuries, a patient harmed by a medical procedure may not know that an accident occurred, let alone who to hold responsible, which prevents healthcare providers from implementing safeguards in the future.

A number of different proposals and experiments have emerged for implementing an alternative, patient safety and systems-oriented reform project, but the one with the greatest traction combines new corrective justice norms

209. INST. OF MED., *supra* note 1, at 52.

210. *Id.*

211. *Id.* at 50–51.

212. *Id.* at 52.

213. *See supra* note 66 and accompanying text.

with informal ADR processes.²¹⁴ This Section explores these alternative norms and processes and contrasts them with earlier generations of ADR interventions.

1. *Alternative Corrective Justice Norms*

Two important normative differences exist between traditional tort negligence and a model of corrective justice that derives from a patient safety paradigm. First, the burden of recognizing and communicating the injury shifts from the injured patient to the provider and, second, the standard for measuring whether a patient's injury deserves compensation shifts from legal negligence to "preventable adverse events."²¹⁵

A patient safety model of corrective justice re-envisioning how parties communicate about a healthcare incident. In the traditional tort system, the onus for recognizing and bringing claims is placed on the injured patient—often the party least informed about whether an injury resulted from substandard care. In order for an injured patient to receive compensation under the tort model, the patient must first recognize the wrong, identify the responsible party, and believe that the harm is deserving of redress.²¹⁶ Then, she

214. For example, some proposals call for state-run, no-fault administrative systems—comparable to the workers' compensation systems—an approach that other countries use effectively. Sage, *supra* note 203, at 31, 39–40; WEILER, *supra* note 20, at 115–58. For discussion of no-fault programs in other countries, see Marie Bismark & Ron Paterson, *No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety*, 25 HEALTH AFF. 278 (2006); Michelle M. Mello et al., *Administrative Compensation for Medical Injuries: Lessons from Three Foreign Systems*, 14 COMMONWEALTH FUND PUB. 1 (2011), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2011/jul/1517_mello_admin_compensation_med_injuries.pdf. Such programs in the United States are limited, both in number and in scope, and enjoy varying levels of success. Gil Siegal et al., *Adjudicating Severe Birth Injury Claims in Florida and Virginia: The Experience of a Landmark Experiment in Personal Injury Compensation*, 34 AM. J. L. & MED. 489 (2008). Others propose creating "Health Courts" for malpractice claims in which specialized judges and trained, neutral medical experts assess claims and apply a broader liability standard than tortious negligence for determining compensation. PAUL BARRINGER, COMMON GOOD, WINDOWS OF OPPORTUNITY: STATE-BASED IDEAS FOR IMPROVING MEDICAL INJURY COMPENSATION AND ENHANCING PATIENT SAFETY (2006), http://commongood.3cdn.net/40b8923081a2c002be_o6m6vzft7.pdf; Michelle M. Mello et al., "Health Courts" and Accountability for Patient Safety, 84 MILBANK Q. 459, 461 (2006) [hereinafter Mello et al., *Health Courts*]. And yet another proposal is for states to create "early offer" programs that provide a structured process for respondents to assess patient claims shortly after filing and offer compensation for economic damages and appropriate attorneys' fees under a statutorily defined scale. JONI HERSCH ET AL., U.S. DEP'T OF HEALTH AND HUMAN SERVS., EVALUATION OF EARLY OFFER REFORM OF MEDICAL MALPRACTICE CLAIMS: FINAL REPORT 1 (2006), <https://aspe.hhs.gov/sites/default/files/pdf/74726/medmalcl.pdf>.

215. For more guidance on vocabulary for classifying iatrogenic injuries due to error, see *supra* note 22.

216. This "naming, blaming, claiming" process was aptly named and described by William L.F. Felstiner, Richard L. Abel & Austin Sarat, *The Emergence and Transformation of Disputes: Naming, Blaming and Claiming . . .*, 15 LAW & SOC'Y REV. 631, 630–49 (1981). Even after determining that a wrong deserves redress, a claimant has additional stages to complete in order to prevail in litigation: recognizing the wrong; motivation to pursue redress; filing a formal complaint in order

must initiate the legal process by filing a formal complaint and demand for relief. Under a patient safety model, however, providers take the initiative to disclose errors and, in exchange, receive legal protections to ensure reporting is not used in future litigation.²¹⁷ This call for greater disclosure and transparency contrasts sharply with the “deny and defend” tactic adopted by those providers who, when something goes wrong, withhold apologies and provide minimal information for fear that any remarks will be used against them in litigation.²¹⁸ Furthermore, by first engaging in direct communication to discuss the problem of an adverse medical event, the parties can avoid the narrow, adversarial “binary clashes” established through formal legal pleading.²¹⁹ Patients and providers become partners with a shared objective—understanding what went wrong to cause the adverse outcome—rather than adversaries pitted against one another in a legal contest.²²⁰

Advocates of shifting the burden of communication from patient to provider expect a number of positive impacts, primarily improved deterrence of future injury and adequate compensation.²²¹ Advocates hope that changing norms of medico-legal culture toward acknowledgement and disclosure of medical errors will lead to a better understanding of why system breakdowns

for the gears of the tort liability system to start turning and, once a claim is made, surviving the slings and arrows of civil procedure. Dauer, *supra* note 163, at 1031. It is worth noting that this problem of claim transformation is not unique to medical malpractice and exists across the civil litigation landscape.

217. See, e.g., INST. OF MED., *supra* note 1, at 109–31.

218. Carol B. Liebman & Chris Stern Hyman, *Disclosure and Fair Resolution of Adverse Events*, in MEDICAL MALPRACTICE AND THE U.S. HEALTHCARE SYSTEM, *supra* note 36, at 191, 195–200; Studdert et al., *supra* note 85, at 287; Troyen A. Brennan & Michelle M. Mello, *Patient Safety and Medical Malpractice: A Case Study*, 139 ANNALS INTERNAL MED. 267, 271–72 (2003). For a contrary view to the idea that the values of patient safety and medical malpractice litigation work at cross purposes, see Joanna C. Schwartz, *A Dose of Reality for Medical Malpractice Reform*, 88 N.Y.U. L. REV. 1224 (2013) (concluding that, based on qualitative research findings, malpractice liability does not necessarily inhibit openness and transparency, nor does information gained from malpractice lawsuits fail to advance patient safety).

219. Michael Moffitt, *Pleadings in the Age of Settlement*, 80 IND. L.J. 727, 737 (2005). In the modern adjudicative system, in which cases settle most often through bargained settlement rather than trial, “[t]he process of crafting a pleading invites disputants and their counsel to conceive of the problem in particular terms” just as “[r]eceiving the other side’s pleadings similarly shapes the way that a disputant internally defines the problem to be resolved.” *Id.* at 736. Thus:

The process of drafting and receiving initial pleadings invites disputants to frame disputes as binary clashes, to conceive of past events in absolute terms, to base solutions solely on entitlements stemming from prior events, and to filter out as irrelevant a vast body of information related to the circumstances underlying the dispute.

Id. at 737.

220. Michael T. Colatrella, Jr., *A “Lawyer for All Seasons”: The Lawyer as Conflict Manager*, 49 SAN DIEGO L. REV. 93, 145 (2012).

221. See, e.g., Jonathan Todres, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, 39 CONN. L. REV. 667, 718–36 (2006) (arguing that open communication and disclosure has potential restorative benefits for providers, patients, and the community).

occur and how to prevent them in the future.²²² Furthermore, greater numbers of injured patients would learn about what happened and be able to request compensation for their injuries, if needed. System-wide costs associated with defensive medicine and litigation would decrease, and more open and cooperative relationships between providers and patients would develop.²²³

A second important distinction between the patient safety paradigm and tort is the criterion for determining whether an injured patient is entitled to compensation. In tort, a patient must prove legal negligence, which requires both affirmative demonstration of a provider's failure to comply with the standard of care and that such failure proximately caused the injury. A patient safety approach utilizes a broader "preventable adverse event" standard. While "adverse events" are generally defined as injuries occurring from "medical management" rather than the patient's underlying health condition,²²⁴ the IOM report defines "preventable adverse event" as an adverse event attributable to "error," where "error" is considered "the failure of a planned action to be completed as intended (in other words, an error of execution) or the use of a wrong plan to achieve an aim (or, an error of planning)."²²⁵ Some errors may fit the definition of legal negligence but not all. For example, a provider who, because of incomplete information in the patient's chart, does not know that a patient has a penicillin allergy and subsequently prescribes the wrong medication, causing injury to the patient,²²⁶ constitutes a system error, but it may not be tortious negligence.

The "preventable adverse events" and negligence standards differ in subtle, yet important, ways.²²⁷ In contrast to tortious negligence, the "preventable adverse event" standard is broader and would include even those

222. See, e.g., Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851 (1994); David Blumenthal, *Making Medical Errors Into 'Medical Treasures'*, 272 JAMA 1867 (1994); Brennan et al., *supra* note 66, at 93, 97.

223. See Brennan et al., *supra* note 66, at 93. While the disclosure approach is gaining ground, results of early studies of whether disclosure programs do—or do not—trigger more litigation and their impact on liability costs are mixed. See Allen Kachalia et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 ANNALS INTERNAL MED. 213 (2010) (showing early disclosure in one program did reduce costs); Laura Field et al., *Does Disclosure Deter or Trigger Litigation?*, 39 J. ACCOUNT. ECON. 487 (2005) (finding that early disclosure does not trigger more litigation); cf. David M. Studdert et al., *Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy*, 26 HEALTH AFF. 215 (2007) (arguing that a simulation to test the hypothesis that disclosure will result in fewer claims suggested that decreases in frequency or cost of malpractice litigation were unlikely and increases likely). Additional information is needed to determine their effectiveness.

224. Brennan et al., *supra* note 44, at 370.

225. INST. OF MED., *supra* note 1, at 28 (citing JAMES T. REASON, HUMAN ERROR (1990)).

226. E.g., Donna M. Woods et al., *Ambulatory Care Adverse Events and Preventable Adverse Events Leading to a Hospital Admission*, 16 QUALITY & SAFETY IN HEALTH CARE 127, 129 (2007) (missing clinical information is a common system error that leads to preventable diagnostic errors); Elder & Dovey, *supra* note 22 at 928.

227. The variation within the literature about how the "preventable adverse event" standard is defined creates additional confusion. See, e.g., Leape et al., *supra* note 44, at 377. For an expanded

harms caused when no specific tortfeasor can be identified. Entitlement to compensation under a “preventable adverse event” standard means the patient’s injury would not have occurred had best practices for healthcare delivery been in place during the course of treatment.²²⁸ The standard seems analogous to common law *res ipsa loquitur* because establishing proximate causation is no longer required. Instead, negligence is implied under the theory that, had best practices been in place, the injury would not have occurred. Thus, this alternative standard replaces the corrective justice model provided by tort. A system-based inquiry (asking, what, if anything, might have gone wrong to yield this adverse outcome?) takes the place of the injured patient bearing the burden of proving which individual actions were substandard and directly responsible for causing her harm.

2. *Alternative Procedures*

Patient safety reform advocates and scholars have proposed a variety of alternative dispute resolution processes to implement this patient-safety-inspired, alternative model of corrective justice, the most widely attempted of which is the Communication and Resolution Program (“CRP”).²²⁹ Here, as in previous generations discussed above, an ADR process is crafted and deployed in the medical malpractice setting as the means to achieve specific reform objectives. CRPs largely exist as privately established programs within closed healthcare organizations or offered by malpractice insurance companies.²³⁰ Programs take different forms but they all operate within the patient safety movement’s systems-based paradigm. CRPs are an ADR process designed for early disclosure of errors and direct conversation between providers and patients.²³¹ A CRP assembles injured patients, their families,

discussion of the difference between negligence and error, both in the legal and medical fields, see Kapp, *supra* note 66, at 754.

228. Mello et al., *Health Courts*, *supra* note 214, at 461. Of course, “best practices” sounds a lot like establishing standards for a duty of care, something that healthcare providers, and many other professions, for that matter, have long fought against for fear that it invites second-guessing of their professional judgment and exposes them to liability even when they may be providing what they deem acceptable care. WEILER, *supra* note 20, at 30 (describing early tort reform efforts to define standards of care by local, as opposed to national, standards and to restrict *res ipsa loquitur* to only certain kinds of injury); SLOAN & CHEPKE, *supra* note 38, at 86–92 box 4.1.

229. Compared to other alternative corrective justice models, discussed *supra* note 214.

230. Michelle M. Mello et al., *Communication-and-Resolution Programs: The Challenges and Lessons Learned from Six Early Adopters*, 33 HEALTH AFF. 20, 22 (2014) (discussing CRPs offered by “noncaptive” professional liability insurance companies neither owned nor controlled by healthcare facilities or at self-insured hospitals).

231. Liebman & Hyman, *supra* note 218. In 2009, President Obama directed the U.S. Department of Health and Human Services to help states and healthcare organizations develop adverse event disclosure and dispute resolution programs as well as to explore new models of healthcare delivery. Under this initiative, the Agency for Healthcare Research and Quality funded seven demonstration projects, totaling \$19.7 million. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, PATIENT SAFETY AND MEDICAL LIABILITY INITIATIVE SUMMARY OF FINDINGS (2014),

and providers for a voluntary discussion of any unanticipated outcome of medical treatment. Conversations usually happen soon after an adverse incident and proceed informally, without set rules or procedures or a third-party adjudicator. The primary inquiry of whether compensation is warranted depends on whether the injury sustained could have been prevented. There is no requirement, as in tort, that the patient's injuries be the direct result of an individual medical practitioner's wrongdoing or failure to abide by reasonable standards of care.

One CRP model, called "early settlement," relies upon internal investigation into whether an error occurred during medical treatment and is used primarily by self-insured hospitals.²³² The CRP process begins when an unanticipated healthcare outcome is reported by hospital staff or complaints from patients and their family members. Then, designated and trained CRP staff with clinical backgrounds investigate the incident to determine whether an error in fact occurred and, if so, why. The CRP staff then meet directly with the patient to discuss the results of the investigation, explain what happened, admit any errors, and apologize for injuries caused. If the investigation uncovered no error, then no compensation is provided; however, if an error is identified, then the hospital works with the patient to reach a mutual agreement about compensation.²³³ The hospital may require the patient to sign a release of future claims.²³⁴ Patients and their families are not legally obligated to participate and can pursue litigation at any point.²³⁵ Whether or not the CRP reports the preventable adverse event to the NPDB depends on the program. For example, some CRPs report only on behalf of the paying institution, not individual clinicians, while others identify individual clinicians only if investigations revealed that person to be primarily responsible for the error.²³⁶

A second CRP model, called "limited reimbursement," does not serve as a substitute process for tort litigation and departs more radically from tort's

http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/liability/liability_initiative.html [hereinafter PATIENT SAFETY].

232. PATIENT SAFETY, *supra* note 231, at 20–22.

233. *The Michigan Model: Medical Malpractice and Patient Safety at UMHS*, UNIV. OF MICH., <http://www.uofmhealth.org/michigan-model-medical-malpractice-and-patient-safety-umhs#summary> (last visited Dec. 27, 2016) [hereinafter *The Michigan Model*].

234. *Id.*; see also Michelle M. Mello et al., *Implementing Hospital-Based Communication-And-Resolution Programs: Lessons Learned In New York City*, 33 HEALTH AFF. 30, 32 ex. 2 (2014).

235. See, e.g., Boothman et al., *supra* note 71, at 137–43 (detailing the open-ended nature of discussions between hospitals, patients, and their respective lawyers and explaining that, ultimately, after exchanging information, "agreements are reached—agreements to drop the claim, agreements to settle (sometimes with an apology), and occasionally, agreements to disagree" and proceed to court). For a comparison among different CRPs, see Mello, *supra* note 230, at 20.

236. Mello, *supra* note 230, at 22.

corrective justice model.²³⁷ Under this model, the liability insurance company works with providers to determine if a patient's unanticipated outcome occurred independently from his underlying disease; there is no investigation into fault or error.²³⁸ If the adverse event is not related to the patient's underlying condition, program administrators pay patients up to \$30,000 for reimbursement of out-of-pocket expenses and loss of time or they may waive medical bills as an additional form of compensation.²³⁹ Because investigation and reimbursement amounts are limited, these programs are reserved for simpler cases and exclude those situations involving death, attorneys, written notices of complaint, or records requests.²⁴⁰ Furthermore, because providers do not issue reimbursements in response to written claims, patients are not required to waive future legal claims, nor is the provider required to report the compensation payment to the NPDB.²⁴¹

While the reasons for implementing CRP include those of earlier ADR interventions—to avoid court litigation and the associated investments of time and financial resources—CRPs also seek to improve communication between patients and providers. CRPs are still too new to assess their full impact. Anecdotal evidence from a few healthcare organizations, however, suggests that legal claims and litigation costs have dropped dramatically after implementation of a CRP, ultimately leading to a leveling of malpractice liability insurance costs.²⁴² However, there are concerns that the increased disclosure built-in to the CRP process will increase tort litigation as more patients learn of potential tort claims.²⁴³ It remains to be seen whether other

237. *Id.*

238. See, e.g., COPIC, “Recognize, Respond, Resolve”: A Successful Approach to Disclosure, PHYSICIAN INSURER, 2007 Fourth Quarter, at 16, 18, https://callcopic.com/who-we-are/newsroom/articles/Documents/4q%2007%20Physician%20Insurer_COPIC%20Article.pdf (summarizing the COPIC program); Mello, *supra* note 230, at 21 (“Program administrators determine whether the unanticipated care outcome was caused by the medical care that was delivered or was the result of the patient’s underlying disease . . .”).

239. Mello, *supra* note 230, at 20–21.

240. *Id.* at 21 ex. 1. The CRPs at West Virginia Mutual Insurance Company and Coverys (formerly ProMutual Group) also exclude cases where patients are dissatisfied with the aesthetic results of cosmetic surgery. *Id.*

241. *Id.*

242. The University of Michigan Health System CRP that reports more than a fifty percent drop in claims and lawsuits, more than fifty percent reductions in legal costs per case, fifty percent shorter timeline for opening-to-closing claims, significantly lower claim payouts when compared to the national average, and unchanged malpractice insurance premiums in spite of increased clinical business. *The Michigan Model*, *supra* note 233. The Stanford University Medical Indemnity and Trust Insurance Company’s CRP, called Process for the Early Assessment and Resolution of Loss (PEARL), noted a drop in claim volume of eighty-seven percent and much faster rates of closing claims. Jeffrey Driver & Renée Bernard, *Enterprise Risk Management*, in *THE SAGES MANUAL OF QUALITY, OUTCOMES AND PATIENT SAFETY* 529, 536 (David S. Tichansky et al. eds., 2012).

243. Allen Kachalia et al., *Does Full Disclosure of Medical Errors Affect Malpractice Liability? The Jury Is Still Out*, 29 *JOINT COMM’N J. QUALITY & PATIENT SAFETY* 503 (2003); Studdert et al., *supra* note 223, at 215.

goals, such as increased patient safety through prevention of medical errors and greater numbers of injured individuals being compensated, will be achieved.²⁴⁴ These concerns are addressed in greater depth by examining Oregon's CRP.²⁴⁵

IV. THE FOURTH GENERATION: EARLY DISCUSSION AND RESOLUTION

Oregon became the first state to enact legislation establishing a statewide, publicly administered CRP that uses a structured ADR process.²⁴⁶ Oregon's Resolution of Adverse Healthcare Incidents Act took effect in July 2014.²⁴⁷ It directs the Oregon Patient Safety Commission ("the Commission"), a semi-independent state agency, to create and administer an Early Discussion and Resolution ("EDR") Program, which has now been in place for two years. The EDR Program provides a sequence of disclosure, discussion, and mediation for patients and their providers to address adverse healthcare incidents and appropriate compensation without resorting to tort litigation.²⁴⁸ This law is significant because it marks the first time a state has institutionalized an ADR-based medical malpractice reform that expressly engages alternate corrective justice norms.

244. For a discussion of one program's findings on these other goals, see Richert E. Quinn & Mary C. Eichler, *The 3Rs Program: The Colorado Experience*, 51 CLINICAL OBSTETRICS & GYNECOLOGY 709, 709–10 (2008) (reporting that the underlying motivation for COPIC's CRP program was a perception that too many liability insurance dollars were paying for litigation and not reaching injured parties, that "truly substandard" care was not caught or addressed by the legal system, and that the tort system cast a shadow of adversarialism that destroyed patient-physician relationships).

245. See *infra* Part IV.C.

246. Other states have enacted laws that enable CRPs. William M. Sage et al., *How Policy Makers Can Smooth the Way for Communication-and-Resolution Programs*, 33 HEALTH AFF. 11, 12 (2014).

247. Adverse Health Incidents Act, ch. 5, § 21, 2013 Or. Laws 1, 7. For more information on the Oregon Patient Safety Commission, see *About*, OR. PATIENT SAFETY COMM'N, <https://oregon-patientsafety.org/about/> (last visited Dec. 27, 2016).

248. Other states have passed legislation promoting early disclosure and resolution but Oregon is the first to establish a structured ADR process for early disclosure. Massachusetts, for example, passed two laws in 2012 that, in conjunction, create opportunity for early resolution. The first requires mandatory disclosure of adverse events resulting in "significant medical complication" by health providers to patients. MASS. GEN. LAWS ch. 233, § 79L (2012). The second is a pre-filing written notice and waiting period requirement that creates time and space for parties to discuss settlement. MASS. GEN. LAWS ch. 231, § 60L (2015). Illinois' legislature created a pilot disclosure and apology program—"SorryWorks!"—directed at a single hospital. 710 ILL. COMP. STAT. ANN. 45/401–45/999 (West 2016), *invalidated by* *Lebron v. Gottlieb Mem'l Hosp.*, 930 N.E.2d 895 (2010). Most recently, in 2015, Iowa passed a law that permits providers to disclose adverse incidents to patients and then engage in confidential discussions about the incident and any compensation that may be warranted. IOWA CODE § 135P.3 (2015). Interestingly, Iowa's law indicates that providers must notify patients of the right to seek legal counsel if they are otherwise unrepresented. Despite these legislative initiatives, there are those who question whether disclosure and apology can really do better than tort litigation. See, e.g., Gabriel H. Teninbaum, *How Medical Apology Programs Harm Patients*, 15 CHAP. L. REV. 307 (2011).

This Part first explores the public policy goals of the EDR program, its structure, and how it differs from lawmakers' earlier ADR interventions. Then, after discussing the initial results from the first two years of the program's operation, it identifies important concerns that need to be addressed in order for the EDR program to accomplish its reform objectives.

A. EDR Policy Goals and Structure

Oregon's lawmakers deliberately designed the EDR Program to respond to both the state's medical malpractice liability problems²⁴⁹ as well as patient safety concerns. Housed under the jurisdiction of the state's Patient Safety Commission, and closely tied to the state's early disclosure reporting program, this ADR procedural intervention is inspired by the patient safety movement's philosophy that openness, transparency, and cooperation reduce medical malpractice liability costs, deliver patient compensation, and deter future injuries more effectively than tort litigation.²⁵⁰ The problems the law intends to fix include both the high costs of the medical liability insurance system as well as harms highlighted by the IOM report: patients suffering preventable injuries yet receiving no compensation and a lack of communication between providers and patients that allows errors to recur.²⁵¹

To achieve these policy goals, the EDR process creates a new method for dispute resolution that sidesteps court and tort. The law establishes a sequence of opportunities for conversation between patients and providers²⁵² regarding an "adverse healthcare incident," which is defined as an "objective, definable and unanticipated consequence of patient care that is usually preventable and results in the death of or serious physical injury to the patient."²⁵³ What constitutes a "serious" physical injury is left open for patients

249. Oregon's medical malpractice insurance rates have decreased in recent years although in the early 2000s, Oregon was considered a "crisis" state by the American Medical Association because its malpractice insurance rates were increasing rapidly. Some providers could not maintain coverage payments, causing concern that providers would leave the practice of medicine, particularly in rural areas. U.S. DEP'T HEALTH AND HUMAN SERVS., ADDRESSING THE NEW HEALTHCARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTHCARE 6, 18 (2003). But more recent reports from Oregon's Department of Consumer and Business Services indicate that premiums have decreased and are continuing to do so. News Release, Dep't of Consumer & Bus. Servs., Oregon Medical Malpractice Rates Continue to Decrease (Apr. 15, 2010).

250. See *Relating to the Resolution of Matters Related to Health Care: Hearing on S.B. 483 Before the Sen. Comm. on Judiciary*, 2013 Leg., 77th Sess. (Or. 2013) [hereinafter *Hearing on S.B. 483*] (statement of Dr. Bud Pierce, President, Or. Med. Ass'n at 8:57–15:40), http://oregon.granicus.com/MediaPlayer.php?view_id=11&clip_id=2380 (last visited Dec. 27, 2016).

251. *Id.* (statement of Or. Gov. John Kitzhaber at 4:46–5:15), http://oregon.granicus.com/MediaPlayer.php?view_id=11&clip_id=2380 (last visited Dec. 27, 2016).

252. For a full list of providers, see Adverse Health Incidents Act § 1(3), 2013 Or. Laws at 1.

253. *Id.* § 1(1), 2013 Or. Laws at 1. As was noted during the Oregon Senate Judiciary hearing, the decision to use the "adverse healthcare incident" as opposed to "negligence" standard was not coincidental—the drafters of the legislation wanted to use the same standard that already existed in

and providers to determine on a case-by-case basis. The injury need not be the result of negligence. Indeed, the statute makes no mention of negligence except to clarify that participation in EDR will toll the statute of limitations for future civil actions and does not prevent a patient from pursuing litigation.²⁵⁴

Either patients and their families or healthcare providers can initiate EDR, but participation in each step is voluntary, meaning that patients and providers both have to opt-in to participate at each stage of the process.²⁵⁵ Once they choose to participate, however, they must comply with specific notice requirements.²⁵⁶ The drafters of the legislation believed that the program would work better if providers were incentivized to participate rather than forced and also wanted to preserve parties' ability to access the courts.²⁵⁷

The first step in the sequence is that someone—a patient, a healthcare provider, or a healthcare facility—makes a request to have a conversation

Oregon law to trigger reporting to state licensing boards. *See, e.g.*, OR. REV. STAT. § 442.831 (2015). This language was developed organically by the working group tasked by the Governor to develop draft legislation and was not modeled on the tort negligence or no-fault standards for determining liability. Telephone interview with Richard Lane, Co-Chair, Task Force on Resolution of Adverse Healthcare Incidents (Aug. 6, 2015).

254. Adverse Health Incidents Act §§ 3(7), 7(1), 7(2), 2013 Or. Laws at 1, 2, 3. The EDR program was conceived to provide an additional avenue for injured patients to obtain compensation, especially those patients that might not be able to secure significant settlements through litigation, but not to replace civil litigation or encroach on citizens' rights to a jury trial. Telephone interview with Richard Lane, Co-Chair, Task Force on Resolution of Adverse Healthcare Incidents (Aug. 6, 2015).

255. *See, e.g.*, Adverse Health Incidents Act § 2(1)(a), 2013 Or. Laws at 1 (“health care facility *may* file a notice . . .”) (emphasis added); *id.* § 2(3), 2013 Or. Laws at 1 (“A[a] patient *may* file a notice . . .”); *id.* § 3(1), 2013 Or. Laws at 2 (“A health care facility or health care provider who files or is named in a notice of adverse health care incident . . . and the patient involved in the incident *may* engage in a discussion . . .” (emphasis added)); *id.* § 5(1), 2013 Or. Laws at 3 (“If a discussion . . . does not result in the resolution of an adverse health care incident, the patient and the health care facility or health care provider . . . *may* enter into mediation.” (emphasis added)). The permissive nature of the bill proposed and ultimately passed by the legislature is a change from the draft legislation proposed by the Governor’s Patient Safety and Defensive Medicine Work Group, which made the disclosure, discussion, and mediation mandatory.

256. *See, e.g., id.* § 2(1)(b)-(c), 2013 Or. Laws at 1 (“If a health care facility files a notice of adverse health care incident . . . facility *shall* provide a copy of the notice to the patient” and “*may* not include the name of a health care provider . . .” (emphasis added)). Oregon administrative rules further elaborate on the procedural requirements for the stages of the EDR process. OR. ADMIN. R. 325-035-0001 to -0045 (2014).

257. *Hearing on S.B. 483, supra* note 250 (statement of Sen. Jeff Kruse at 22:13), http://oregon.granicus.com/MediaPlayer.php?view_id=11&clip_id=2380 (last visited Dec. 27, 2016); *see also id.* (written statement of Gwen Dayton, General Counsel, Or. Med. Ass’n), <https://olis.leg.state.or.us/liz/2013R1/Downloads/CommitteeMeetingDocument/4494> (last visited Dec. 27, 2016). Additional incentives to participate include waiving the statutory requirement for parties to negligence claims to participate in some form of dispute resolution. OR. REV. STAT. § 31.250 (2015). There are currently no plans to make the program mandatory, in large part because the Patient Safety Commission does not want to be in the position of policing and enforcement. Telephone interview with Melissa Parkerton, Director, Early Discussion and Resolution Program (July 8, 2015).

about an adverse healthcare incident.²⁵⁸ The request is made through the Oregon Patient Safety Commission, which serves as an impartial third party convenor, notifying other parties of the request for conversation and connecting patients and providers to one another.²⁵⁹

Once all parties have been notified of the adverse healthcare incident, they can choose to discuss the incident or decline the request. In those discussions, providers may communicate about how future errors will be prevented²⁶⁰ and may also determine whether the incident warrants compensation.²⁶¹ The statute explicitly states that these are not discussions of malpractice claims in order to avoid triggering state and federal malpractice reporting requirements.²⁶² Indeed, except for offers of compensation, which must be in writing, all communications among EDR participants must remain oral.²⁶³ If the provider makes an offer of compensation, it must advise the patient of the patient's right to consult with an attorney before accepting it.²⁶⁴ If discussions do not result in a resolution, then the parties may proceed to the second step, mediation.²⁶⁵ Patients retain the right to proceed with a traditional claim in court if the EDR process proves unsatisfactory.²⁶⁶ Throughout the EDR process, discussion communications are confidential, do not constitute an admission of liability, and may not be disclosed in any subsequent adjudicatory proceeding, which includes judicial, administrative, or arbitration proceedings.²⁶⁷ EDR's structural design elements derive from the patient safety movement's objectives and therefore offer a radical departure

258. Adverse Health Incidents Act § 3, 2013 Or. Laws at 2. When the patient files the notice, the Commission notifies all providers named in the notice; however, if a provider or facility files the notice, then the providers bear the responsibility for notifying the patient. *Id.* §§ 2, 3.

259. OR. PATIENT SAFETY COMM'N, EARLY DISCUSSION AND RESOLUTION ANNUAL REPORT: JULY 2014 –JUNE 2016, at 2–3 (2016), http://oregonpatientsafety.org/docs/edr/EDR_Annual_Report_July2014-June2016.pdf (discussing the Commission's role).

260. Adverse Health Incidents Act § 3(4), 2013 Or. Laws at 2.

261. *Id.*

262. *See infra* IV.C.

263. Adverse Health Incidents Act §§ 3(4), 3(6), 2013 Or. Laws at 2.

264. *Id.* § 3(5), 2013 Or. Laws at 2.

265. *Id.* The Oregon Patient Safety Commission is charged with developing and maintaining a roster of qualified mediators. Telephone interview with Melissa Parkerton, Director, Oregon Early Discussion and Resolution Program (July 8, 2015). In order for mediators to be on the Patient Safety Commission's approved roster, the mediators completed a mandatory training provided by a private, non-profit organization, the Oregon Mediation Association. *Id.* The content of the training included information about medical malpractice and negligence. *Id.*

266. *Hearing on S.B. 483, supra* note 250 (statement of Dr. Bud Pierce, President, Or. Med. Ass'n at 14:15), http://oregon.granicus.com/MediaPlayer.php?view_id=11&clip_id=2380 (last visited Dec. 27, 2016).

267. Adverse Health Incidents Act § 4(2), 2013 Or. Laws at 2. "Communications" include not only oral and written communications made during discussions, but also any memoranda, work product, documents, etc. prepared in connection with the discussions. *Id.* § 4(1), 2013 Or. Laws at 2.

from the previous ADR procedural interventions used in the medical liability context.

B. Comparing EDR to Earlier ADR Interventions

Oregon's Early Discussion and Resolution program institutes an alternative corrective justice paradigm in ways earlier generations of ADR-based medical malpractice reforms could not, and cannot. EDR shows promise because, for the first time, it offers an ADR process structured in such a way that it can respond to fundamental problems with the medical liability system. According to its statutory design, EDR is completely disconnected from courts and legal procedures. Conversations include the parties most intimately involved in or impacted by the adverse medical incident, and parties' communications are not restricted by, or limited to, narrow legal issues. Each of these unique characteristics will be discussed in turn.

Previously, state regulation of medical malpractice was tied to legal claiming. Legislatures used a plaintiff's act of filing a claim as the regulatory access point for imposing screening panels, mediation, or binding arbitration. For any of these specialized procedures to occur, the patient first had to discover the injury, think it must have been caused by negligence, and then decide to pursue a complaint.

But, in EDR, the patient's legal claim is not the triggering event that begins to move the gears of dispute resolution. Instead, anyone can request a conversation after an adverse outcome of medical treatment. EDR democratizes access to the resolution process by shifting responsibility from the patient and her family to everyone informed about the incident—the individual healthcare provider, the provider's employer, or a health facility. Thus, by decoupling the ADR process from the initiation of a formal complaint, the connection between the EDR process and formal litigation diminishes. The content of the discussion can broaden to include the incident itself, the concerns of all affected parties, and the methods to compensate injuries fairly and prevent future errors.²⁶⁸ And because these conversations happen soon after an incident occurs, often before any legal claim, they may be less litigation-centric than conversations in earlier generations of ADR.²⁶⁹

A second important difference between EDR and some previous ADR procedural reforms concerns the participants and the nature of their discussions. Screening panels, binding arbitration, and pre-trial mediation operate within the adversarial framework of litigation, where relevant information is defined as that which pertains to proving legal arguments. Lawyers do much of the talking, and parties, in some cases, may be more concerned about

268. See Moffitt, *supra* note 219, at 751.

269. See, e.g., Farber & White, *A Comparison*, *supra* note 59, at 777, 780–82 (concluding that patients involved in cases initiated through the hospital's incident reports were less litigious than patients who initiated cases through a complaint or lawsuit).

avoiding saying the wrong thing. Of all the previous generations of ADR, mediation perhaps permits the greatest opportunity for open communication and transparency because of its confidentiality protections, which enable parties to make gestures of sympathy during mediation without fear that it will come back to haunt them in court. But, once litigation begins, very few providers actually participate in mediation. Lawyers for the provider come from the liability insurer, so the potential for direct communication between the provider and the injured patient and the patient's family is limited.²⁷⁰ In contrast, the EDR discussions are open to any and all individuals involved in the incident, and providers must reasonably accommodate anyone who wishes to participate. While EDR does not go as far as other CRPs, which may require providers to participate unless they have a good reason not to,²⁷¹ it still enables the effected individuals to open direct lines of communication and fosters transparency more than any previous ADR intervention.

Third, unlike binding arbitration and medical screening panels, but similar to mediation, in EDR there is no third party acting as a finder of fact and assessing the merits of the patient's legal claims. Discussions between patients and providers take the form of direct negotiations or, in some cases, mediated discussions.²⁷² Because there is no third party decisionmaker, the patient and the providers together determine the outcome of discussions and whether to formalize these discussions into a legally enforceable contract.²⁷³ Similarly, unlike binding arbitration, the patient is not contractually obligated to accept EDR offers and those offers cannot become part of a subsequent court record, as do the findings of some medical screening panels. Of course, EDRs can raise a different and related issue: providers or healthcare administrators simultaneously function as the respondent and the entity determining whether compensation is warranted and for what amount.²⁷⁴

Fourth, in EDR, because the incident has not yet been transformed into a legal claim, theoretically, tortious negligence need not be the only yardstick for determining whether the patient is entitled to compensation. Instead, parties can rely on the vague "preventable adverse health care incident" standard discussed earlier.²⁷⁵ Screening panels and binding arbitration still involve assessing whether the plaintiff can show that the treatment was substandard and whether the treatment, even if substandard, was the legal cause of the

270. Liebman, *supra* note 184, at 144–45.

271. *See, e.g.*, Mello et al., *supra* note 230, at 22 (showing that the University of Illinois Medical Center at Chicago requires mandatory provider participation and the University of Michigan Health System presumes provider participation unless provider refuses).

272. Liebman & Hyman, *supra* note 218, at 205.

273. *Id.* at 205–06.

274. *See infra* Part IV.C.2.

275. Adverse Health Incidents Act, ch. 5, § 1(1), 2013 Or. Laws 1, 1. "Adverse health care incident" means an objective, definable and unanticipated consequence of patient care that is usually preventable and results in the death of or serious physical injury to the patient." *Id.*

injury. In pre-trial mediation, the parties often negotiate based on how likely they are to prevail in court, bargaining in the shadow of the law.²⁷⁶ This is not to say, however, that discussions and negotiations in EDRs are somehow untethered from the outcomes of other, litigated cases²⁷⁷ or uninfluenced by tort norms,²⁷⁸ but they are less confined by them.

C. Progress? Evaluating the Newest Generation of Dispute Resolution Procedure

Oregon's EDR program, as a stand-alone alternative, represents the farthest move away from the traditional tort system and litigation over liability for medical injuries. After only two years in operation, it remains too early to draw definitive conclusions about whether Oregon's program will accomplish its broader policy objectives of reducing costs associated with medical malpractice liability litigation, increasing access to compensation, and improving safety of the healthcare delivery system.²⁷⁹

However, initial data gathered from EDR participant surveys identify areas for improvement and yield important lessons for other state legislatures interested in experimenting with a public, statewide communication and resolution program. This Section discusses some early results from Oregon's program and then explores three additional concerns that will also need to be addressed.

1. Early Results

The Oregon Patient Safety Commission gathers data about EDR by asking individuals who initiated, or were the subjects of, a Request for Conversation to complete a "Resolution Report," no matter whether an EDR conversation occurred or not.²⁸⁰ There have been sixty-seven Requests for EDR since it began in 2014. Unfortunately, the Commission only received back Reports related to thirty-six EDR Requests and, of those Reports received, a

276. See, e.g., Robert H. Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L.J. 950, 985-88 (1979).

277. Ben Depoorter, *Law in the Shadow of Bargaining: The Feedback Effect of Civil Settlements*, 95 CORNELL L. REV. 957, 974-77, 979-83 (2010) (discussing the substantive feedback effect of settlements, a phenomenon in which settlement outcomes influence what parties and judges view as appropriate outcomes for subsequent, similarly situated cases).

278. Eisenberg, *supra* note 137 (noting that negotiation, like adjudication, is heavily influenced by legal norms, with parties frequently invoking principles, rules, and precedents to create leverage in bargaining).

279. OR. PATIENT SAFETY COMM'N, *supra* note 259, at 4 (explaining that no mechanism currently exists for capturing total numbers of adverse medical incidents or medical malpractice claims in Oregon, which means there is no baseline for comparing the patient safety and medical liability pictures before and after EDR).

280. *Id.* at 3. Individuals can complete Reports even if EDR was declined or no conversation occurred. *Id.* at 7.

third were incomplete.²⁸¹ Nevertheless, information from the Reports sheds some light on who elects to participate in EDR and why, what kinds of adverse incidents prompt EDR Requests, which topics parties discuss in EDR, as well as parties' perceptions of the process.

When it comes to soliciting and participating in EDR, patients are far more likely to initiate a Request for Conversation than are healthcare professionals.²⁸² Male and female patients are equally likely to engage EDR; however, older patients (in their fifties and sixties) are much more likely to request EDR than their younger counterparts.²⁸³ Adult children or the spouses of patients sought EDR more often than parents or guardians of patients.²⁸⁴ In forty-two percent of all patient Requests for EDR for the first two years, at least one healthcare professional agreed to participate.²⁸⁵ There is no data explaining why healthcare providers and facilities affirmatively accepted EDR Requests although there is information about why they might decline. Healthcare providers most often declined patient EDR Requests because they intended to use an alternative process or were advised against participation by their liability insurer or legal counsel.²⁸⁶ Healthcare facilities primarily declined patient Requests for EDR because they elected to use their own, internal mechanisms to resolving patient complaints or because the incident involved someone not employed by the facility.²⁸⁷ Interestingly, no healthcare professionals cited fear of reporting to the Oregon Medical Board or the NPDB as a reason for refusing to participate.²⁸⁸

EDR Requests arose from different kinds of adverse medical incidents and EDR conversations included a range of topics. Both patients and healthcare providers asked for EDR following invasive surgical procedures or when there was a delay in care.²⁸⁹ When EDR conversations took place, providers described discussing many more topics than did patients. Providers said they talked with the patients about an adverse event and why it occurred;

281. *Id.* at 4.

282. *Id.* at 4. Out of sixty-seven Requests for EDR, fifty-seven came from patients and ten came from healthcare professionals. *Id.* at 5.

283. *Id.* at 11. Patient-initiated EDR Requests may be directed at multiple healthcare providers or facilities and each of these provider entities can choose to accept or decline the Request. *Id.* at 5.

284. *Id.* at 12.

285. *Id.* at 5.

286. *Id.* at 5–6. A few providers indicated they had declined to participate because they learned that the facility would not be participating and elected not to participate either; that they did not believe the incident met the definition of an adverse healthcare event; or that they had already addressed the incident through another process. *Id.* at 6.

287. *Id.* at 5–6. A few healthcare facilities declined because they believed the event was specific to the particular physician involved. *Id.* at 6.

288. *Id.* at 5.

289. *Id.* at 7. Patients also asked for EDR for events involving medication, healthcare-related infections, and medical devices, among others. *Id.*

information about an error that occurred; patient's health, future treatment, and follow-up; as well as how additional information would be shared moving forward.²⁹⁰ Patients, however, described discussing a much narrower set of issues, such as an adverse event and why it happened, that a medical error did *not* occur, and whether or not there might be compensation.²⁹¹ One notable finding from parties' Reports is that their accounts of EDR conversations rarely overlap and sometimes even contradict each other.²⁹²

Perhaps the most intriguing data gleaned from the Resolution Reports reveals stark differences in patients' and healthcare professionals' perceptions of the EDR process. First, most healthcare providers indicated they were satisfied or very satisfied with the EDR process while patients' responses ranged more widely from very satisfied to not at all satisfied, with more than half indicating they were not at all satisfied.²⁹³ Second, in a couple of cases, the providers said a satisfactory resolution was reached whereas the patients said that nothing was resolved and that the healthcare professionals had shown a "lack of accountability or respect."²⁹⁴ And, third, no correlation could be found between whether or not an apology was extended during EDR and either the parties' satisfaction with the process or their belief that the underlying issue had been resolved.²⁹⁵ In fact, healthcare professionals reported making offers of apology far more often than patients reported receiving them, suggesting that the parties may have different views on what passes for an apology.²⁹⁶

The Commission draws some important lessons from the data collected thus far. For example, it observes that healthcare organizations that respond promptly to patients' EDR requests are far more likely to reach satisfactory resolutions in EDR because the longer patients are left without information the more likely they are to lose trust in the resolution process, become suspicious that the provider is hiding something, and feel anxious or disrespected.²⁹⁷ The recommendation for healthcare providers and facilities is to

290. *Id.* at 9.

291. *Id.* at 9.

292. *Id.* at 11. In one case, the provider reported providing information about an error that occurred, which was the exact opposite of what the patient reported (information that an error did *not* occur). *Id.*

293. *Id.* at 9. The number of responses is very small, only twenty-five total, which makes it difficult, if not impossible to draw any kind of conclusion about EDR satisfaction ratings.

294. *Id.* at 10. The Commission's annual report hypothesize that the patients' perception of disrespect stems from a healthcare facility or provider's lack of participation in the EDR process and that securing full participation from healthcare professionals is an important piece of patients' satisfaction. *Id.*

295. *Id.* at 10. Indeed, Resolution Reports indicated that resolution could be reached *without* an apology.

296. *Id.* at 11. In six cases, the Commission received responses from both patient and healthcare professionals that mentioned the offer of an apology. Healthcare professionals reported giving an apology in each of the six cases whereas only three patients reported receiving an apology. *Id.*

297. *Id.* at 12.

engage patients promptly after an adverse incident, ideally within seventy-two hours, with a preliminary conversation.²⁹⁸ Another important lesson is that adverse incidents involving multiple stakeholders—the healthcare facility where the incident occurred, the facility’s liability insurer, all the healthcare professionals plus their employers and liability insurers—can become enormously complex and difficult to coordinate for EDR, particularly if they have different views of who bears responsibility for the incident.²⁹⁹ The Commission recommends establishing clear lines of communication among potential stakeholders in advance so that, in the event they receive a patient request for EDR, they can respond promptly and in coordination.³⁰⁰ And, finally, another clear lesson from the first two years of EDR is that patients and their families need more help navigating the process.³⁰¹ Help could come in the form of a social worker or even a legal advocate, discussed further below,³⁰² as well as the insertion of a mediator to facilitate EDR conversations. The apparent ubiquity of misunderstanding about what is said during EDR and the mismatch in parties’ perceptions of the process is a clarion call for a mediator. As the Commission observes, healthcare professionals may rely on difficult-to-understand technical language or “continue on script” when patients are experiencing strong emotions and perhaps “temporarily unable to listen.”³⁰³ Mediators, particularly those trained in facilitation, can help clarify what parties are saying, what is being heard, and how they view one another.³⁰⁴

All of these recommendations from the Commission surely will improve the functioning of the EDR program. Nevertheless, because EDR departs from long established legal norms and procedures, it raises additional concerns to those flagged by the Commission that need further attention.

2. *Critical Issues Requiring Attention*

Oregon’s EDR program has the potential to solve problems with the medical liability system precisely *because* it is so far removed from the tort system’s traditional notions of adversarialism and negligence. However, this

298. The reasons for provider delay might be because of internal approval process and should not be because of communication barriers since, once an individual submits an EDR request, an automatic notification is sent out and can be viewed online.

299. *Id.* at 14.

300. *Id.*

301. *Id.* at 16.

302. *See infra* Part IV.C.2.

303. OR. PATIENT SAFETY COMM’N, *supra* note 259, at 11.

304. Bush, *supra* note 167, at 36 (discussing the “value added” of including a mediator in negotiations).

very same distancing raises a number of concerns that will need to be addressed in order for EDR to effectuate the kind of substantive reforms envisioned by the patient safety movement.³⁰⁵

a. Incentivize Providers to Participate

The first concern is whether providers will be incentivized to participate in a voluntary process like EDR. The low number of provider Requests for EDR (only ten in the first two years) signals that providers do not think they need EDR.³⁰⁶ This seems counterintuitive since, in EDR, providers have considerable procedural power. They control whether to disclose a preventable adverse event in the first place, whether to respond promptly to a patient complaint, and whether to offer apologies or compensation. In order for EDR to work, providers will have to buy-in to the process and believe that it presents a better alternative than the status quo of tort litigation.

What would be sufficiently motivating for a provider to choose EDR? One potential enticement could be that EDR provides a constructive process to disclose and address harmful errors where before there was none. While some providers may feel morally or ethically compelled to disclose errors, many do not.³⁰⁷ Some providers remain suspicious about whether such disclosure practices will make them vulnerable to more liability³⁰⁸ or do not feel empowered to come forward and identify incidents in which a patient received poor care.³⁰⁹ For those providers who are afraid of litigation, embarrassed about the error, or simply unsure about how to disclose information so that it can have a positive effect,³¹⁰ EDR offers a safe outlet. Providers have an opportunity for disclosure in a contained, confidential environment and in the context of a structured process with an articulated purpose.

Nevertheless, even if providers do see the benefit of the EDR process, they still may not participate because it remains unclear how EDR will impact

305. Allen Kachalia et al., *Legal and Policy Interventions to Improve Patient Safety*, 133 CIRCULATION 661, 668 (2016) (discussing the many attempted strategies for improving patient safety over the years, observing that, “success is rarely ‘baked’ into the intervention itself,” and concluding that “[h]ow it is implemented and the environment in which it is thrust matter enormously and independently determine effectiveness”).

306. OR. PATIENT SAFETY COMM’N, *supra* note 259, at 3.

307. *See supra* Part III.A.

308. BAKER, *supra* note 14, at 95–98 (summarizing studies that suggest that fear of litigation alone cannot explain why medical providers are so reluctant to disclose errors and calling for new incentives for disclosure other than restrictive tort reform).

309. *See, e.g.*, Jenny Firth-Cozens et al., *Attitudes to and Experiences of Reporting Poor Care*, 8 CLINICAL GOVERNANCE 331, 335 (2003).

310. Thomas H. Gallagher et al., *Disclosing Harmful Medical Errors to Patients*, 356 NEW ENG. J. MED. 2713 (2007) (“Historically, physicians have been conflicted about disclosure. They have wanted to be open with patients but have been fearful of litigation, embarrassed, or unsure of effective disclosure strategies. A professional ethos of discretion or even coverup after harmful errors predominated . . .”).

future litigation rates and providers' liability insurance. Some studies of disclosure programs suggest that alerting more patients to medical errors may actually increase the volume of tort litigation as more patients learn of potential tort claims.³¹¹ Collectively, this might lead to greater liability insurance costs for providers—the very issue that has captivated legislators since the early days of medical malpractice reform. Then again, the disclosure programs examined by these studies operated in isolation, without an accompanying alternative dispute resolution process like EDR. It may be that the only way to secure provider participation at this early stage in EDR is by adjusting the law to require providers to participate in patient-initiated Requests for Conversation and perhaps offering additional protections from future liability in all but the most egregious cases.

With time, once EDR is used more widely, these additional incentives and requirements could be phased out. Patients and providers may discover that engaging with one another about a medical injury in an alternative venue proves more satisfying, less expensive, and more predictable than litigating. Providers may also discover that, as the Commission warns, failure to respond to patients' EDR requests in a timely manner may exacerbate patients' feelings of anger and distrust, ultimately leading to more conflict than resolution; in which case, it is very much in the providers' interest to engage EDR early and often. It still remains to be seen how disclosure, when coupled with an open and informal ADR process, will affect patients' decisions about whether to pursue a legal claim. If policymakers want to institutionalize the kind of culture change envisioned by the patient safety movement, they will need greater buy-in from providers, which first requires a better understanding of the direct financial impact EDR will have on providers.³¹²

b. Help Patients Access Legal Assistance

EDR's distancing from the traditional tort system raises another important issue that legislators will need to address: how patients will access legal counsel. The Commission acknowledges that patients, particularly those without legal or medical expertise, will need help understanding the risks and benefits associated with the EDR process. For example, should a patient agree to accept an offer of compensation and release a provider from future liability? If a provider offers to reimburse the patient for certain healthcare costs, will the patient keep that money, or must some or all of it be shared with her health insurance company? And, what are the tax implications for a patient who accepts monetary compensation from a provider

311. Kachalia et al., *supra* note 243; Studdert et al., *supra* note 223, at 215.

312. For a discussion of one program's findings on these other goals, see Quinn & Eichler, *supra* note 244, at 709–10.

since, technically, they are not proceeds from settlement of a lawsuit?³¹³ While Oregon's EDR statute places responsibility on providers to inform patients of their right to consult an attorney before agreeing to any offer of compensation,³¹⁴ it is not yet clear if, and how, these patients will access the legal help they will need to make informed decisions.³¹⁵ Yet, even as it recognizes patients need for support and advocacy, the Commission sounds tentative about encouraging patients to bring legal representation to EDR as "facilities and providers can be less willing to participate if the patient is represented."³¹⁶ It may seem like a difficult policy choice: whether to trade providers' willingness to participate for patients' access to sound advice. But for EDR and any other programs like it to be fair, the choice is clear—patients should not be left to fend for themselves.

And, indeed, patients in such programs will likely be left to fend for themselves because accessing legal counsel for EDR operates very differently than under the conventional tort system. The tort system depends upon contingency fee arrangements to help patients with valid claims find legal assistance. Under these arrangements, an injured patient pays for an attorney's services only if the attorney succeeds in securing a settlement award.³¹⁷ Furthermore, most jurisdictions cap attorneys' contingency fees at thirty percent of the award.³¹⁸ As a consequence, lawyers are incentivized to take only those cases that have both a good chance of winning and a sizeable enough potential payout to cover the attorney's out-of-pocket expenses.³¹⁹ EDR, designed to avoid the costs of litigation, also avoids the financial rewards of litigation, and therefore may not prove attractive to lawyers. Sidestepping litigation not only changes the attorneys' role but also their cost-benefit analyses of whether to take a case.³²⁰ Furthermore, a thirty percent contingency

313. I.R.S. PUB. NO. 4345, SETTLEMENTS – TAXABILITY 1 (2015) (explaining specific kinds of circumstances that render proceeds from a lawsuit settlement as taxable income).

314. Adverse Health Incidents Act, ch. 5, § 3(5), 2013 Or. Laws 1, 3.

315. See, e.g., Rob Rubinson, *A Theory of Access to Justice*, 29 J. LEG. PROF. 89, 100–02 (2005) (explaining that, given there is no constitutional right to representation in civil suits, lawyers are economically incentivized to aid only in dispute resolution that promises substantial financial gains and involves affluent parties).

316. OR. PATIENT SAFETY COMM'N, *supra* note 259, at 17.

317. WEILER, *supra* note 20, at 62–63.

318. *Id.* at 62.

319. Mello & Studdert, *supra* note 52, at 11, 13; Daniels & Martin, *supra* note 39. A number of states require potential plaintiffs to obtain a "certificate of merit" from an attorney before filing in court. See Heather Morton, *Medical Liability/Malpractice Merit Affidavits and Expert Witnesses*, NAT'L CONFERENCE OF STATE LEGISLATURES (June 24, 2014), <http://www.ncsl.org/research/financial-services-and-commerce/medical-liability-malpractice-merit-affidavits-and-expert-witnesses.aspx>.

320. Felstiner et al., *supra* note 216, at 645–47 (citing studies that show how lawyers affect the transformation of their clients' disputes by serving as gatekeepers to legal institutions, shaping outcomes in accordance with their own interests, and providing expertise that moves client matters further along than they might otherwise).

fee seems too steep for the limited counseling or negotiating a lawyer might do in EDR. Helping patients in EDR, therefore, will require a different business model for lawyers.

There are creative ways to build access to legal counsel into the EDR model. For example, an in-house CRP program in Massachusetts has partnered with the Massachusetts Bar Association to increase patient access to legal representation in its early settlement process. Attorneys are provided with a “best practices” guide explaining how the program differs from litigation and how patients should be represented when they participate.³²¹ Attorneys are told that a compensatory fee structure may not be appropriate since they will not be engaging in the “extensive and expensive discovery and expert review associated with traditional litigation and trial.”³²² It is recommended instead that they consider an hourly rate or reduced contingency fee. For a public, statewide program like Oregon’s EDR, partnerships with local or state bar associations, best practices information or trainings for attorneys, as well as an available roster of attorneys who are competent in this alternative process, could all ensure that appropriate legal assistance is available and accessible for patients in this alternative corrective justice system.

c. Clarify Federal Reporting Requirements

Finally, another issue requiring attention is whether EDR’s ability to skirt NPDB reporting requirements is in fact good public policy. Under federal law, healthcare entities and insurance companies must report to the NPDB any payments made to settle a claim or satisfy a judgment on behalf of a provider against whom a claim for medical malpractice was brought.³²³ Further, state licensing boards and peer accreditation organizations must report adverse actions taken against providers.³²⁴ The federal reporting program collects information on malpractice claims against individual providers in order to create a way for hospitals, employers, and licensing entities to track and assess the provider’s professional competence and conduct.³²⁵ While the ultimate purpose of the NPDB is to improve the quality of medical care, some in the medical profession view it as an unwarranted “blacklisting”

321. JONATHAN CANEL ET AL., BEST PRACTICES FOR PATIENT REPRESENTATION IN THE CARE PROGRAM AND OTHER CRPS (2015), http://www.macmi.info/files/2514/2247/3482/FINAL_2014_05_01_BIDMC_-_HNMCP_Report1_4.pdf.

322. *FAQs*, MASS. ALL. FOR COMM’N AND RESOLUTION FOLLOWING MED. INJURY, <http://www.macmi.info/attorneys/> (last visited Dec. 27, 2016).

323. 45 C.F.R. § 60.7 (2015).

324. *Id.* §§ 60.8–60.16.

325. *Id.* §§ 60.1–60.3.

that can destroy a physician's career.³²⁶ At least one study shows that providers become more reluctant to settle liability claims if settlement triggers the NPDB mandatory reporting requirement.³²⁷

Oregon's EDR program provides a way around the NPDB reporting requirement. The law explicitly states that a payment made as a result of EDR discussion or mediation does *not* constitute a "payment resulting from a written claim or demand for payment."³²⁸ It further exempts notices of adverse healthcare incidents from state statutory reporting requirements to professional licensing boards.³²⁹ Despite concern from constituents,³³⁰ the U.S. Department of Health and Human Services, which oversees the NPDB, agreed that oral EDR discussions could be excluded from reporting requirements, but not written offers.³³¹

How EDR will affect existing "tensions and ambiguities" of the NPDB remains unclear.³³² On the one hand, keeping settlement discussions oral in order to avoid the NPDB may create the extra incentive that providers need to engage in disclosure and settlement. On the other hand, a patient, particularly one without a lawyer, might not fully understand the legal and financial implications of a settlement offer that is not reduced to writing.

Just as previous ADR experiments have been tried and tested for their ability to deliver reform objectives, robust empirical study of Oregon's EDR program should continue. In order to know whether this alternative approach advances corrective justice, we need to assess the impact of EDR on providers' incentives to disclose errors and participate in conversation, on patients'

326. Van Tassel, *supra* note 70, at 2057–62 (referring to the NPDB as "blacklisting" and describing the range of consequences for a physician who receives a negative report).

327. HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVS., NPDB GUIDEBOOK E-18 to 19 (2015) (explaining which forms of medical malpractice payments must be reported to the NPDB) [hereinafter NPDB GUIDEBOOK]; Teresa M. Waters et al., *Impact of the National Practitioner Data Bank on Resolution of Malpractice Claims*, 40 INQUIRY 283, 289–92 (2003) (showing that the greatest impact of the NPDB has been providers unwillingness to settle smaller claims (less than \$50,000)).

328. Adverse Health Incidents Act, ch. 5, § 6, 2013 Or. Laws 1, 3.

329. *Id.* §§ 11–16, 2013 Or. Laws at 4–6.

330. See, e.g., *Hearing on S.B. 483, supra* note 250 (written statement of Rick Bennett, Dir. of Gov't Relations, AARP Oregon), <https://olis.leg.state.or.us/liz/2013R1/Downloads/CommitteeMeetingDocument/1949> (last visited Dec. 27, 2016) (raising concerns that Oregon's legislation lacks sufficient notice requirements, does not adequately safeguard individuals entering the alternative resolution process, and that consumers are insufficiently represented on the task force created to evaluate the EDR program).

331. U.S. Dep't of Health & Human Servs., Decision, Appropriate Medical Malpractice Payment Reporting to the National Practitioner Data Bank (NPDB) in Light of Recent Medical Malpractice Reforms in Massachusetts and Oregon (May 20, 2014); see also NPDB GUIDEBOOK, *supra* note 327. For more discussion of the HHS reaction, see Haavi Morreim, *Candor About Adverse Events: Physicians Versus the Data Bank*, 45 HASTINGS CTR. REP. 9 (2015).

332. William M. Sage et al., *Bridging the Relational-Regulatory Gap: A Pragmatic Information Policy for Patient Safety and Medical Malpractice*, 59 VAND. L. REV. 1263, 1291–1305 (2006).

ability to access legal counsel and make informed decisions about settlement offers, as well as on existing federal reporting requirements.

V. CONCLUSION

For almost fifty years, state legislatures have experimented, and continue to experiment, with ADR interventions in the hope that adding new procedural elements to medical liability claims will change parties' interactions and ultimately yield improved policy outcomes. Some of these experiments have not succeeded while others show promise.

Statutes imposing ADR processes like screening panels, binding arbitration, and mandatory mediation, which rely upon a tort-based approach to corrective justice, proved ineffective in addressing persistent, structural problems within the U.S. medical malpractice system. These ADR processes were used to restrain access to courts and to increase the likelihood that, if filed, lawsuits would ultimately settle. They did not address the high incidence of patient death and injury, lack of transparency and communication, uncompensated and undercompensated patients, and the perpetuation of medical errors.

The rise of the patient safety movement, with its values of transparency, cooperation, and inclusivity, opened the door to an alternative vision of corrective justice in the medical malpractice context. It has also created a new role for ADR not only as an alternative process but also a promising alternative venue for patients and providers to engage one another directly about preventable injuries caused by medical treatment.

Considering all of these ADR interventions collectively, a pattern emerges: with each successive dispute resolution procedure, both the substantive elements of tort and the formal rules of litigation diminish in importance. The process becomes increasingly informal and consensus-based as parties, rather than a third-party neutral, retain control over the ADR outcomes. Also, the reference point for the ADR process moves away from tort-based determinations of fault and towards an alternative, systems-based paradigm of compensation.

Of all the ADR interventions used in the medical malpractice context, the first generation, medical screening panels, revolves most tightly around tort litigation. The medical screening panel considers the evidence in light of the elements of tort negligence, operating as a procedural checkpoint to assess the merit of a plaintiff's claim and determine whether it is worthy to continue on to court. Thus, the substantive tort analysis and the question of future litigation remain very much at the center of the process.

Orbiting further away from court litigation are second and third generation interventions like binding arbitration and mediated settlement. Binding arbitration is removed altogether from the tort system because it replaces court litigation as a method of dispute resolution. Parties are therefore less

concerned that they would be in other ADR processes about continuing on to litigate the same issues in court. However, binding arbitration remains tied to the court process both in its format, since it operates as private adjudication, as well as its legal analysis to determine tortious negligence.³³³ Conversely, mediation uses a non-adjudicative structure but does not replace the courts. Indeed, both pre- and post-filing mediation mandates anticipate litigation and encourage pre-adjudication settlement of medical malpractice claims. Mediation, however, in contrast to arbitration and medical screening panels, allows for more than an analysis of the parties' legal rights and entitlements under tort by creating a confidential space for those intangible components of dispute resolution—apologies and acknowledgments of pain and hardship.³³⁴

And finally, the newest generation of an ADR tort reform, exemplified by Oregon's EDR program, is situated even farther away from tort litigation though it, too, is not completely free from the tort system's gravitational pull. Both EDR's procedural and substantive dimensions provide alternative frameworks for corrective justice. The informal discussion and mediation between parties are designed to replace the need for a court process, though, unlike privately contracted binding arbitration, does not displace it entirely. Determining whether compensation is warranted relies upon a systems-based inquiry that imposes an expectation of disclosure on providers and applies a "preventable adverse event" standard instead of negligence.

The EDR process opens up a truly alternative world: one that uses a different yardstick to measure whether compensation is owed, resolves disputes without formal legal claiming, and limits the state's regulatory reach. This alternative ADR design has the potential to address profound shortcomings in the medical liability system in ways previous ADR interventions could not. However, as ADR based procedural reforms move farther away from traditional, tort based principles and towards alternate conceptions of justice, they also raise new concerns. The challenge for policymakers, attorneys, providers, and patients will be to understand how to resolve these problems so that ADR can function as a vehicle for delivering, rather than eroding, corrective justice.

333. See *supra* Part II.B and accompanying notes.

334. Dauer & Marcus, *supra* note 58, at 204 (footnote omitted) ("Litigation translates plaintiffs' motivations into claims for money, even though the motivation may have originally been non-monetary. . . . Mediation, in contrast, is characterized by unlimited flexibility of remedy, by the effort to retranslate articulated demands back into recognized needs, and by an explicit strategy of creating rather than inhibiting effective communication between participants." (citing ROBERT A. BARUCH BUSH & JOSEPH P. FOLGER, *THE PROMISE OF MEDIATION* (1994); JAY FOLBERG & ALISON TAYLOR, *MEDIATION: A COMPREHENSIVE GUIDE TO RESOLVING CONFLICTS WITHOUT LITIGATION* (1984); CHRISTOPHER W. MOORE, *THE MEDIATION PROCESS* (2d ed. 1996); NEW DIRECTIONS IN MEDIATION (Joseph P. Folger & Tricia S. Jones eds., 1994); LAWRENCE SUSSKIND & JEFFREY L. CRUIKSHANK, *BREAKING THE IMPASSE* (1987); WILLIAM URY ET AL., *GETTING DISPUTES RESOLVED* (1988))).