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SYMPOSIUM: EVOLVING MEDICOLEGAL CONCEPTS

# Medical Malpractice Reform: The Role of Alternative Dispute Resolution

**David H. Sohn JD, MD, B. Sonny Bal MD, JD, MBA**

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**Abstract**

*Background* Alternative dispute resolution (ADR) refers to techniques used to resolve conflicts without going to the courtroom. As healthcare and malpractice costs continue to rise, there is growing interest in tactics such as early apology, mediation, and arbitration in the medical arena.

*Questions/purposes* (1) Why is ADR needed? (2) Is ADR useful in health care? (3) What are the current legal and political developments favoring ADR? (4) What obstacles remain?

*Methods* We performed MEDLINE, PubMed, and Google Scholar searches with key words "medical malpractice", "ADR", and "alternative dispute resolution" to obtain public policy studies, law review articles, case analyses, ADR surveys, and healthcare review articles.

*Results* Early apology and disclosure programs report 50% to 67% success in avoiding litigation as well as substantial reductions in the amount paid per claim. Mediation boasts 75% to 90% success in avoiding litigation, cost savings of $50,000 per claim, and 90% satisfaction rates among both plaintiffs and defendants. Arbitration is viewed as less satisfying and less efficient than mediation but still more time- and cost-effective than litigation. The current legal environment is favorable to ADR with recent court decisions upholding pretreatment arbitration clauses. The main obstacle to ADR is the mandatory reporting requirement of the National Practitioner Data Bank (NPDB).

*Conclusions* ADR has the potential to help reform the current tort system, reducing cost and increasing both parties' satisfaction. Easing the reporting requirements for the NPDB would lead to more widespread acceptance of ADR among physicians.

## Introduction

The US healthcare system needs reform [40, 45]. The current tort system is extremely expensive with estimated direct costs of $76 to $122 billion per year [6]. It is also lengthy and inefficient. Over 60% of lawsuits are summarily dismissed as having no merit, yet still cost up to $80,000 to defend [24, 45]. When cases do go to trial, they are lengthy with average trial lengths of 5 years [16, 17, 45] and have less than 10% success rates for the plaintiff [34]. Even when successful, the majority of the awards go to the attorneys, not the plaintiffs [24].

The early attempts at tort reform included caps on noneconomic damages. These have proven to be the most reliable form of tort reform in terms of cost containment [20] yet are not politically viable as a result of strong political funding by trial lawyer interests to a Democratic-controlled Senate. This has led to renewed interest in alternative dispute resolution (ADR) to altogether avoid the litigation arena as a form of tort reform [13].

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D. H. Sohn (✉)
Department of Orthopaedic Surgery, University of Toledo Medical Center, 3000 Arlington Avenue, Toledo, OH 43551, USA
e-mail: david.sohn@utoledo.edu

B. Sonny Bal
Department of Orthopaedic Surgery, University of Missouri, Columbia, MO, USA

When properly implemented, ADR has an excellent track record of avoiding litigation, decreasing overall cost, and increasing satisfaction among both plaintiffs and defendants [8, 9, 13, 16, 18, 27, 36, 41]. ADR, however, has not been as quickly embraced in medical malpractice as in other fields of commercial and civil litigation [9].

We address the following questions: (1) Why is ADR needed? (2) Is ADR useful in health care? (3) What are the current legal and political developments favoring ADR? (4) What obstacles remain?

## Search Strategy and Criteria

We performed MEDLINE, PubMed, and Google Scholar searches with key words "medical malpractice", "ADR", and "alternative dispute resolution" to obtain public policy studies, law review articles, case analyses, ADR surveys, and healthcare review articles. Using these searches we identified 1305 articles. We excluded 1260 articles based on language and relevance to the medical field and were left with 40 articles.

## Why Is Alternative Dispute Resolution Needed?

The US healthcare system is in need of tort reform. Litigation as a primary means of dispute resolution is costly and irrational. The cost of litigation is enormous both in terms of direct costs and indirect costs. The US Department of Health and Human Services has estimated that between $76 and $126 billion is spent per year on litigation in medical malpractice [45]. In addition, there are indirect costs to the healthcare system in the form of defensive medicine, estimated at between $83 and $151 billion [22]. Worse, the costs continue to escalate. Since 1976, malpractice premiums have soared 920% [5] mostly because jury verdicts continue to rise at an alarming rate. Between 2001 and 2002, the national jury award in medical liability cases almost doubled from $3.9 million to $6.2 million [17]. Jury awards in medical malpractice are roughly 17 times greater than nonmedical fields [14].

The tort system is also irrational. More than 60% of all medical malpractice lawsuits are summarily dismissed by courts as being meritless nuisance suits [10, 45]. Closed claim studies show that only 15% of all lawsuits filed actually contain negligence [6, 24, 45]. On the other hand, only 3% of those truly injured by medical negligence actually sue [24]. In other words, the uninjured sue and the injured do not. Furthermore, the money does not even go to the plaintiffs. Only 28 cents of every dollar actually makes it to the plaintiff [31, 45]. The rest is consumed by lawyers and administrative fees. Clearly there is need for reform.

Early tort reform focused on placing caps on noneconomic damages such as pain and suffering. Although economic damages such as medical expenses and lost wages are unlimited, caps on more difficult to quantify damages such as pain and suffering have been limited by states to help avert malpractice crises. Caps limiting this portion of recovery have proven effective when implemented at the state level. Caps in California reduced the overall expenditure of medicine by 5% to 9% after passage of the 1975 MICRA laws [22]. It is estimated that this reduction in defensive medicine, if implemented on a national level, would save $83 to $151 billion per year. Caps also increase access to care. In Texas, similar caps were passed in 2003; after that, the state saw the return of more than 3000 physicians who had earlier left the state, the arrival of 22 new insurance carriers, and a 22% reduction in premiums over a 2-year period [45]. Caps also, perhaps surprisingly, help the plaintiff. A RAND Corporation study looking at awards before and after MICRA found that caps led to redistribution of awards from attorneys to plaintiffs [30]. This is likely because case lengths decreased by almost two-thirds after caps were enacted.

Despite this, attempts to pass caps on a national level have been unsuccessful. In a Democratic-controlled Senate, caps on a federal level are not politically realistic. Caps are vigorously opposed by trial lawyer interests, who strongly support the Democratic Party. According to the Center for Responsive Politics, one of the nation's strongest special interests is the American Association for Justice, whose main political agenda is fighting tort reform. Of the $31.6 million donated in the past 20 years, over 91% has gone to the Democratic Party [35]. Howard Dean, former Democratic National Convention Chair, stated the main reason tort reform was not included in the 2010 healthcare reform was to avoid running afoul of these interests [2]. In short, if tort relief is to come, it will not be politically, at least not in the near future.

## Is Alternative Dispute Resolution Useful in Health Care?

### Early Disclosure and Apology

The forms of ADR can be thought of as a spectrum from informal to formal. The most informal form of ADR is negotiation. This is simply a meeting between the two parties to discuss the conflict and seek to achieve some type of resolution. These exchanges may be facilitated by programs designed to facilitate apologies or even legislation attempting to mitigate emotion and anger by providing a safe haven for parties to disclose matters fully without fear that such could be misused later as proof of negligence at

trial [1, 15]. These are known as early disclosure and apology programs.

Although the desire to hear an explanation and an apology are often the main driving forces behind a lawsuit in medical malpractice, paradoxically, the threat of litigation deters the same things. Physicians and hospital systems fear that an apology will be used against them as an admission of negligence, and open dialogue about what happened may simply provide further impetus for the plaintiff's attorney at trial. Thirty-five states have passed some form of "I am sorry" legislation, which allows physicians to offer confidential and inadmissible apologies. Not all apology laws are the same. Some such as Colorado's protect both the apology as well as any admission of fault. Others such as Indiana's protect the apology but not an admission of fault. So although a statement similar to "I'm sorry this happened to you" is protected, a statement such as "I'm sorry I did this to you" is not. Other states such as Nevada, Florida, New Jersey, Pennsylvania, Oregon, Vermont, and California make the protection conditional. Apologies are only protected if the physician gives early disclosure of adverse events [42]. Furthermore, statutes may differentiate between which types of apologies, written or oral, are protected. Detailed review of each state's apology statute is beyond the scope of this article, and consultation with a health law attorney is recommended for each state's specifics.

Apology statutes, although helpful, are not always necessary. The University of Michigan Health System enacted an Open Disclosure Program in 2002, although the state has no statutes protecting physician apology. The Michigan program focuses on setting realistic expectations during the informed consent process and an early patient-centered apology and explanation process if an adverse event is encountered [3]. Despite no legislative protection, the program has seen a reduction in yearly claims from 262 to 82 [37, 42]. The University of Illinois, after implementing a similar program, saw a reduction of malpractice filings by 50%. Of 37 cases in which the hospital acknowledged preventable error and apologized, only one patient filed suit [37].

Another case study suggests early disclosure and apology reduces the amount paid during settlement. In 1987, the Veterans' Administration (VA) Hospital in Lexington, KY, instituted an apology program that not only admitted and apologized for errors but actually assisted patients in the filing of claims. This led, not surprisingly, to this particular VA being in the top 25% of all claims filed. However, it was also in the bottom 25% of total monies paid out, suggesting that early ADR substantially reduces the payment per claim [23].

Some limitations of these case studies need to be noted. Although the State of Michigan does not have an apology statute, it does have substantial caps on noneconomic damages. In the case of the Lexington VA, all federal government physicians are protected from personal liability by the Federal Tort Claims Act. Nonetheless, the basic principles that early disclosure and apology reduce both the number of claims and ultimate payouts have been validated elsewhere. In Colorado, a physician-directed medical malpractice insurance carrier named COPIC instituted an early apology program in 2000 called the 3Rs—Recognize adverse events, Respond quickly, and Resolve issues. The program included both apology and early disclosure with a focus on preserving the physician–patient relationship. The result was a 50% reduction in malpractice filings, a decrease in settlement costs of 23%, and a startlingly low average settlement award of roughly $5000 [3].

## Mediation

Mediation is a negotiation that is facilitated by a neutral third-party mediator. This mediator can be an attorney or retired judge, but trained mediators usually have higher success rates. The most important characteristic of mediation is that it is nonbinding. When parties choose to attempt mediation, it is not binding and parties can break off the negotiations at any time. This is of particular benefit to the physician defendant. Jury trials, contrary to popular opinion, overwhelmingly result in a verdict for the physician, almost 90% of the time in fact [17]. The physician may want to preserve his or her right to go to trial if he or she feels they are wrongly sued [16]. A nonbinding form of ADR such as mediation preserves this right. Mediation is also relatively informal. The parties are typically not accompanied by attorneys and so the process is short and relatively inexpensive [13, 36, 39]. The informal atmosphere leads to the ability to be creative in remedies. For example, where litigation can only lead to monetary awards, mediation may lead to solutions such as implementation of future safety protocols or expressions of sympathy from the physician, which the patient may find more satisfying. In one survey of plaintiffs in medical malpractice trials, for example, money was only the third most important reason for suing after an apology and information about why the adverse event occurred [41]. Some creative solutions used have included memorials for family members who have died, opportunities to help train incoming residents by discussing their difficult experiences, and donations to charity [8, 13]. Because mediated settlements by definition are agreed on by both parties, they are associated with the greatest durability and satisfaction [27, 41].

Numerous medical centers have used mediation effectively to divert potential claims from litigation. The

University of Michigan, Johns Hopkins, Rush-Presbyterian Medical Center, the University of Pittsburgh Medical Center, and Drexel have all implemented mediation programs with the assistance of premediation agreements [13]. Unlike prearbitration agreements, these agreements do not require a waiver of either party's access to a jury trial. However, as a condition of treatment, patients agree to try mediation before pursuing litigation with any potential claims. According to Jury Verdict Research, an average of $50,000 in legal expenses alone is saved in each case, which is mediated rather than taken to trial [13, 27, 41].

Mediation boasts extremely high satisfaction rates among both plaintiffs and defendants, approximately 90% [41]. The informal process allows both parties to speak for themselves, which is understandably cathartic for both. Physicians, in particular, appreciate an opportunity to express frustration at being sued when they are not at fault and describe the toll this takes on their ability to provide care for other patients. Mediated cases are also extremely time-efficient. According to one survey of 13 ADR organizations, the average length of mediation is only 1 to 3 days with cases closing from start to finish between 85 and 165 days [41]. By comparison, it is not unusual for a litigated case to take 5 years or more to resolve [16, 30]. Attorney fees are also sharply decreased. Attorneys surveyed noted that their average preparation time for trials was 36 hours compared with only 2.5 hours for mediation [41].

Two success stories in institutionalized mediation programs are those at Drexel and the University of Pittsburgh Medical Center. Drexel's program, launched in 2004, uses two comediators, both medical malpractice attorneys trained in mediation. Of 20 cases mediated between March 2004 and August 2005, 17 were settled for an 85% success rate [8]. The remaining three cases were litigated and all resulted in verdicts for the defendant, perhaps disproving the notion that only weak cases go to mediation. Pittsburgh similarly instituted a formal mediation program in 2004. Using a single mediator model, the institution successfully settled 24 of 27 cases over a 1-year period for an 88% success rate and estimated $1,000,000 in savings in defense costs alone [8].

Mediation, however, may be less effective when ordered by the court. The State of North Carolina has a widespread practice of court-ordered mediation, and an empiric study performed by the Duke and Wake Forest law schools found the rates of success in such courts were much lower than expected at only 23.7% [33]. By comparison, noncourt-ordered mediation typically has between 75% and 90% success in avoiding litigation [18, 19, 41]. One reason for this is the different structure of court-ordered mediation. In typical mediation, there are no attorneys present unless the mediator him- or herself is an attorney. There are simply the parties and a mediator to facilitate discussion. In the North Carolina model, a mediator met with the attorneys for the parties, who acted as the primary speakers, with little participation by the parties themselves. Factors that drove settlement included the use of trained mediators instead of retired judges or attorneys and cases in which the mediator explored worst-case scenarios for both parties. Factors that did not affect the settlement rate included the amount of money demanded by the plaintiff and cases in which the mediator interjected his or her own opinion about the merits of the case. When cases did not get settled, the vast majority ended up in verdicts for the defendants (86%) [33].

## Arbitration

Arbitration is a more formal and binding form of ADR. Parties are typically represented by attorneys who argue the case before an arbiter or arbitration panel. The arbiter then issues a decision. The main distinction of arbitration is that the arbiter's decision is typically binding. It is popular therefore among parties who fear the capricious nature of jury verdicts and is seen as a means of risk management [16]. One form of arbitration that is gaining popularity in the healthcare field is the pretreatment arbitration agreement. This is an agreement that patients sign as a condition of being seen by a healthcare provider stating that should a dispute arise, it will be handled through arbitration. Physicians may include such clauses in their initial contracts with new patients and so protect themselves from litigation. Several legal challenges have been raised to these clauses, but in every case, such clauses have been deemed legal and binding [43]. As such, pretreatment arbitration clauses are used by clearly on the rise, whether in agreements between physician and patient [36], physician and malpractice insurance provider [16], or patient and insurance company or HMO [13, 21]. Even entire states are starting to require arbitration [13]. Wisconsin, for example, requires aggrieved medical malpractice parties to go through ADR before litigation, and Pennsylvania provides for court-ordered ADR as a Rule of Civil Procedure whenever requested by a healthcare defendant [8].

The binding nature of arbitration can hurt both the plaintiff and defendant alike, however. The overwhelming majority of times that a physician is sued, there is no negligence involved, as the outcomes of trial litigation have confirmed repeatedly [6, 24, 45]. Physicians may therefore find it advantageous to go to jury trial to clear their names and prove there was no negligence [16]. Binding arbitration means the physicians forego this right and must take their case to an arbiter. Although arbiters award much more modest awards than juries, they are also more likely to award some type of award to the plaintiff

whether there is negligence or not [36]. The propensity of arbiters to force compromise is one criticism of arbitration [27, 33]. Other critiques are that it is too rigid and adversarial, only one step removed from an actual trial [13, 16, 36]. Costs are higher than mediation and the process is more acrimonious because lawyers are involved [8, 9, 27, 36]. Satisfaction rates among both parties are lower than mediation [36, 41] and, similar to jury trials, the only form of redress is monetary. Still, there are definite time and cost savings compared with litigation [8, 27, 36, 41], and the fact that it is binding means many potential lawsuits are diverted from the courthouse.

Arbitration also has some unique strengths. Arbiters can be selected for their unique scientific background. This makes arbitration a particularly good choice for disputes over specific issues of scientific fact. Rather than leaving the matter to a jury that is unlikely to comprehend the issue—or to a negotiation when there is a great discrepancy between the understanding of the scientific issues at play—arbitration has a unique advantage of having a skilled and knowledgeable arbiter as a decider of fact. Arbitration is also, almost by definition, extremely effective at avoiding litigation. As a binding decision, arbitration effectively only goes to trial when one of the parties appeals the decision. Even this is expedited, however. The decision of an arbiter can only be overturned for procedural error, bias, or fraud [13].

### Pretrial Screenings

Pretrial screenings are informal screenings before litigation by a neutral party to assess the relative strengths of each party's case and determine whether the trial merits going to trial. It is a way to screen out cases that are not based on merit and save costs to both parties. One reason this is particularly well suited to the medical field is the high number of meritless cases in this field [24, 45]. Roughly 70% of cases are dismissed by a judge during summary judgment as meritless [10]. There are, nonetheless, costs associated with defending lawsuits, typically between $24,000 and $90,000 [17]. Pretrial screenings allow both parties to avoid these costs. Pretrial screenings are helpful for a second reason as well. One reason for the high number of meritless claims is that plaintiffs are often confused about what does and does not constitute negligence. The practice of medicine, particularly surgery, carries inherent risk. Complications such as infection, bleeding, pain, and death are inevitable no matter how well trained or conscientious the physician is. For the patient, however, complications may trigger the desire for some form of redress; when combined with emotion, the result is a lawsuit. Physicians, fearful of litigation, may try to avoid speaking with the injured patient after an adverse event or defend themselves by blaming the patient's noncompliance or biology. This engenders anger and distrust, and patients sue to seek information about why something bad happened and to hear an apology for it as much if not more than for simply money [1, 15]. Pretrial screenings help educate plaintiffs that these are not proper grounds for a successful lawsuit and help steer them to more fruitful grounds such as mediation. Roughly half of all states require pretrial screening before pursuing litigation in medical malpractice [13].

Pretrial screening, also known as early neutral evaluation, is a mandatory process in at least three states: Wisconsin, Maine, and New Mexico. In Wisconsin, a panel consisting of a lawyer, healthcare provider, and layperson screen each case before litigation. Although called Medical Mediation Panels, these in function are pretrial screening panels that act to exclude meritless claims and expedite resolution of claims with merit [46]. In Maine, a medical malpractice claim must be reviewed by a three-member prelitigation screening panel. Two members are physicians. The screening panel can be bypassed by consent of both parties. Alternatively, the panel can, again with the consent of both parties, act as a binding arbitration panel [25]. The earliest medical malpractice pretrial screening panels date back to the 1960s. In New Mexico, pretrial review panels were initially introduced as a voluntary resource in 1962. After a wave of malpractice litigation crisis, the statute was upgraded to a mandatory process in 1976. During the next 20 years, the New Mexico panels screened more than 2100 medical malpractice cases. Of these, almost 75% were successfully directed away from litigation [13].

## What Are the Current Legal and Political Developments Favoring Alternative Dispute Resolution?

There is currently an advantageous legal climate for ADR. In the legal case of *Estate of Ruszala v Brookdale Living Communities*, a New Jersey arbitration clause in a nursing home preadmission agreement was at issue. The agreement clearly violated a 2003 New Jersey statute barring such agreements. Despite this, the Appellate Court found that arbitration clause was not unenforceable per se. This was because the New Jersey statute was preempted by the Federal Arbitration Act. Similar rulings have been found in the Supreme Courts of Illinois and Missouri [43]. Also, in *Moore v Woman to Woman Obstetrics & Gynecology*, a pretreatment arbitration clause was disputed. At issue was the fact that the pretreatment clause was included as part of the physician's patient intake process. The Moore court ruled that there is nothing per se unenforceable about this

arrangement [43]. Taken together, these show a disposition of courts, even courts in states generally hostile to tort reform, to embrace ADR.

Politically, also, there is impetus for ADR. Caps on damages may be an effective means of cost control, but they may not be realistic at the federal level at this time. During the recent healthcare debates at the national level, there was considerable support in favor of caps on noneconomic damages. Douglas Elmendorf, the Director of the nonpartisan Congressional Budget Office, recommended that caps on noneconomic damages be included in last year's healthcare reform, because the bill lacked any substantial cost containment provisions without it [11, 12]. President Obama's National Commission on Fiscal Responsibility and Reform, a bipartisan commission charged with deficit reduction, similarly called for caps on noneconomic damages to help control costs [38]. Despite these public policy pressures, the 2010 Patient Protection and Affordable Care Act (PPACA) notably did not pass caps or any other meaningful form of tort reform [32]. Howard Dean, former Democratic National Party Chairman, has opined that this was to avoid running afoul of trial lawyer special interests [2], which contribute 91% of their funds to the Democratic Party [35]. In fact, an earlier version of the bill actually contained a protection clause for trial lawyers, stating that healthcare reform must "not limit attorney fees or impose caps on damages" [26]. Unlike capitated damages, however, ADR is supported by the American Bar Association and is thus politically a far more feasible form of tort reform [8, 36]. From the trial attorney's perspective, litigated malpractice may be far more lucrative than a mediated claim. However, it is also higher risk. Less than 10% of cases result in a victory for the plaintiff [34]. An ADR claim, however, involves less work and has guaranteed pay. So it is a win-win-win for plaintiffs, physicians, and attorneys.

There is recognition among all parties that reform is necessary. PPACA, for example, allocates $50 million in grants and pilot studies to develop medical malpractice reforms so long as they are not caps on noneconomic damages [32]. ADR fits perfectly in this niche as a means of tort reform, which is politically feasible, has legal support from attorneys and judges, and has some early evidence showing efficacy, decreased cost, and high satisfaction.

## Obstacles to Alternative Dispute Resolution

A major obstacle to more widespread use of ADR in the medical malpractice field is the National Practitioner's Data Bank (NPDB) [13, 27–29]. The NPDB is a database of all settlements and jury verdicts rendered against a physician regarding medical malpractice claims. It was intended to help prevent rogue doctors from simply relocating to a new hospital or a new state when an adverse track record was established. As such, any settlement or jury award becomes part of a physician's permanent record and affects his or her ability to obtain staff privileges at a new hospital or to obtain a license to practice in a new state. NPDB data also play a role in determination of malpractice insurance premiums. Physicians with multiple settlements in their name are deemed high risk, much like drivers with multiple moving violations or accidents, and premiums correspondingly go up.

The problem with the NPDB is that it discourages the efficient settlement of nonnegligence cases. The vast majority of malpractice cases filed do not contain negligence. Patients often sue as a result of emotional reasons or as a result of unrealized expectations. It would be inefficient for both parties to thoroughly litigate such a case. However, to arrive at a settlement, however nominal, would have detrimental repercussions for the defendant [9]. Although the physician may furnish a note explaining the circumstances, many physician defendants prefer to avoid having their names entered in the NPDB by pursuing litigation [13]. Thus, perhaps ironically, litigation may protect the physician defendant's interest better than ADR. Perhaps for this reason a growing number of malpractice insurance providers are forcing binding arbitration clauses on physicians, known as "consent to settle" clauses, so that they can force settlements on physicians even when the defendant is unwilling [16].

Another obstacle to more widespread ADR use is distrust. Although ADR has seen rapid growth in other fields, its use in health care has lagged behind [9]. This is not because ADR is unfamiliar or unknown, but because ADR has been tried and did not work. In the 1970s and 1980s, various forms of tort reform were implemented, including several that were both mandatory and very clumsy. For example, some states instituted widespread court-annexed and medical screening panels, applying them awkwardly to cases that were very close to trial. The strength of ADR is that there is a variety of options that are best implemented flexibly rather than in a mandatory, one-size-fits-all fashion. For example, arbitration is best when there is a real evidentiary point of disagreement, particularly when a complex issue of science is involved. This is because an arbiter can be selected for his or her particular scientific expertise. On the other hand, when the driving impetus of a lawsuit is a patient's need for information and apology, nonbinding and informal mediation is the best choice. The problem with early ADR tort reform initiatives is that the type of ADR forced on parties was often an internally inconsistent form of mandatory nonbinding ADR, which frustrated all parties as ineffective and time-wasting [9].

## Discussion

ADR has become increasingly prominent in the medical malpractice reform discussion, in part because more proven reforms such as caps on noneconomic damages are politically not feasible, at least at this time. Early disclosure and apology programs, mediation, arbitration, and pretrial screenings are all forms of ADR that have been successfully implemented in the medical arena. Generally, the majority of claims that go through ADR are successfully resolved without litigation at considerable cost savings to the defendants and high satisfaction for the plaintiffs. However, major challenges, especially from the mandatory NPDB reporting requirements for settlements, remain. We therefore addressed the following questions: (1) Why is ADR needed? (2) Is ADR useful in health care? (3) What are the current legal and political developments favoring ADR? (4) What obstacles remain?

We recognized limitations to our review. First is the relative paucity of information. Unlike trials, which become a matter of public record, settlements such as those reached in early apology negotiations, mediations, or arbitration are privileged and confidential. This is part of the appeal of ADR, but also makes data hard to gather. Second, the quality of available data is limited. The gold standard in health policy is the data on caps on noneconomic damages, because there is a control and experimental group. Physician expenditure and patient morbidity and mortality were measured before and after enactment of caps and the results analyzed [22]. No such data exist for ADR. Rather, most of the information available about ADR is self-reported institutional data and survey data from plaintiffs, defendants, and attorneys participating in the ADR process. The potential for bias is obvious and perhaps even shows in the numbers. When self-reported, the success rate is noted to be 75% to 90% [18, 19]. On the other hand, in a study in which independent observers were dispatched to each court-ordered mediation proceeding, the success rate was much lower at 23% [33]. One explanation could simply be the difference between court-ordered ADR and voluntarily engaged ADR. Another, however, could be bias.

One obvious solution to increasing the use of ADR is to allow for some exceptions to the reporting requirements to the NPDB. An exception could be made, for example, for no fault settlements. There is inherent risk to any surgery, and complications can arise through no fault of the surgeon. Some feel that complications should be compensated regardless of fault or no fault. Allowing a no fault exception would allow for a settlement to be made but not recorded in the NPDB. This would fairly balance the competing interest in reporting and warning the public at large of incompetent and negligent physicians while preventing such cases from driving up the costs of health care and litigation. Another solution could be creation of a national apology law. Australia, British Columbia, England, and Wales [7] all provide for apology and disclosure protection in medical malpractice cases at a national level, and something similar could be considered in the United States. In 2005, a bill was introduced by then Senators Hillary Clinton and Barack Obama entitled "The National Medical Error Disclosure and Compensation Act ("MEDiC"). This legislation, which did not pass, would have mandated automatic disclosure of medical error to the patient and provide protection for any apologies that arose during negotiation of compensation. In other words, there was not only a shield protecting the physician, but also a sword prodding him or her in the back. It also was not comprehensive, protecting only apologies and not privileging the early disclosure itself. Even this has problems, however. A major issue with any federal statute is the issue of federalism. Should the federal government pass a single law or allow the states to decide for themselves? Clearly, ADR efforts at the state level have been mostly successful and reflect individual, creative efforts at resolving the so-called medical malpractice crisis. A federal law would certainly reduce the confusion currently existing about what type of apology law, if any, is in a particular state. On the other hand, the fact that there is such a variety of apology laws perhaps indicates that reasonable minds can disagree about what type of law should be in place and the matter may best be left to each individual state, consistent with the doctrine of limited federal powers over the states.

The evidence so far suggests the current medical malpractice crisis should be addressed by both caps on damages and using ADR mechanisms. Although ADR has not always been viewed favorably, and it has been applied awkwardly in the past, there is mounting evidence that it can be effective. Mediation in particular has the advantages of addressing nonmonetary patient interests, resulting in high satisfaction among both plaintiffs and defendants. Impediments to more widespread use of ADR include the NPDB, which attaches a stigma to settlement even in no fault cases as generally poor perceptions of ADR as a result of past failings. Future implementations of ADR should focus on flexibility and early interventions, and both first-generation tort reform and more consistent, comprehensive apology protection laws will almost certainly aid in its successful implementation.

In summary, there is need for ADR because the current default for resolving conflicts in medicine is the tort system, which is expensive [6, 22] and irrational [4, 20, 24, 44]. It is unrealistic to hope for political tort reform as a result of the strong influence of trial lawyer special interests [35] on the Democratic Party [2], which currently controls the Senate. Relief, then, must come from elsewhere.

A variety of ADR techniques have been successfully used in medical malpractice. Early apology and disclosure programs report 50% to 67% success in avoiding litigation as well as substantial reductions in the amount paid per claim [3, 37, 42]. Mediation boasts 75% to 90% success in avoiding litigation [8, 18, 19], cost savings of $50,000 per claim [13, 17, 41], and 90% satisfaction rates among both plaintiffs and defendants [41]. Arbitration is viewed as less satisfying and less efficient than mediation but still more time- and cost-effective than litigation [8, 9, 13, 16, 27, 36, 41].

The current political and legal environment is optimal for embracing ADR. The ABA embraces ADR [8, 36], and several recent court opinions have shown judicial favor for arbitration clauses [43]. Politicians also recognize the need for reform [38] yet are reluctant to embrace more well-studied and proven reforms such as caps on noneconomic damages [2]. Sizeable grants therefore are available to expand on the preliminary data on the efficacy of ADR in health care [32]. The main obstacle to ADR is the punitive reporting requirements of the NPDB [13, 27]. Should these be relaxed, it is likely that physicians will be more receptive to using ADR to resolve healthcare disputes.

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