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Solving the Med-Mal Riddle Through Co-Mediation

Proposal would have a physician serve as one of two neutrals

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In November, the Law Tribune published a special section on medical malpractice, including an article by Nora Freeman Engstrom, a professor at Stanford Law School, titled "Should Med-Mal Cases Be Removed From Court System?" Engstrom told a "cautionary tale" from the experience of the Vaccine Injury Compensation Program in addressing the potential benefit of "moving medical-malpractice cases outside the traditional court system into freestanding, dedicated tribunals," i.e., "health courts." Engstrom's bio indicates that "her current work explores the day-to-day operation of the tort system and particularly the tort system's interaction with alternative compensation mechanisms," so her observations deserve weight.

The idea of health courts for medical malpractice cases has initial appeal because the current system is basically broken, if, indeed, it ever worked well. The list of deficiencies is long: cases can take years to wend their way through the courts, by the end of which plaintiff patients and defendant physicians or other medical providers are drained and disillusioned, if not battered and beaten. Discovery costs tens of thousands of dollars more than is needed. Some cases in which the injured patient should be entitled to reasonable compensation for actual error have fallen by the wayside because the process is so costly. Many plaintiffs counsel do not have the wherewithal to see claims to conclusion. Nonmeritorious cases clog the courts and alienate health care providers as well as the public. Occasional huge verdicts threaten provider organizations and purportedly justify overzealous defense tactics by their insurance companies and lead to cries for reform from providers and politicians.

Before grasping for health courts as the solution, we should take care to examine whether that makes the most sense. Has it been thought all the way through, or is it another attempt at reform that will not obtain the necessary buy-in of the interested players and, if adopted, could produce unintended negative consequences? Creating a separate system, difficult to undo, that does not fully address the needs of the actors in that system can present limitations and pitfalls of its own.

There may well be a better way that does not require legislation, by adjusting the present system without coercion to the current players, who would participate only voluntarily. As with any voluntary system, the incentive to opt in must be great enough to encourage active and

good-faith engagement. So the system must be designed to address the current problems, meet the needs and address the misgivings of the participants, and have sufficient flexibility to allow for adjustments as the system develops.

Here's the model we have in mind, which if pursued seriously could make a significant difference should all parties participate in its design and implementation: mediation early in the case, either before or shortly after suit is filed, with "co-mediators," one of whom is a physician and the other a process-oriented, interest-based professional mediator.

One key objective would be to screen cases for merit based on scrutiny of the medical record through an open discussion of the existence, or not, of error, cause and extent of claimed injury or condition, and reasonable compensation if appropriate. The physician brings objective and neutral medical expertise and insight to the process. This role is not as much "evaluative" (to use mediation lingo) as it is probing for what actually happened and why, and how that might be considered by all parties in relation to the community standard of care. The impartial physician leads a discussion with patients' counsel, and the patients themselves as appropriate and helpful, along with the involved health care providers (physicians and provider organizations, most notably hospitals) and their counsel and insurers that is intended to create a framework within which the facts can be scrutinized with unbiased care.

The nonphysician mediator contributes what good mediators do. That is to facilitate and guide an in-depth process that addresses the dispute at all levels, including the facts and law (i.e., the legal positions) and, even more importantly for this purpose, the interests of all parties, which are driven by needs, both financial and emotional, and, in the case of the providers, professional.

Since space here does not permit a full-blown description of and case for this approach, consider the following digest of reasons that warrant careful thought by all constituencies in the med-mal claims arena:

• First and foremost, this approach can effectively address perhaps the most critical elements of any injury claim: ensuring that legitimate claims are compensated reasonably and fairly within a reasonable time frame; nonmeritorious claims are identified and addressed accordingly; and the parties to the process feel that their voices have been fully heard and their interests met. Mediation is a well-established means for accomplishing just that.

• The bedrock of mediation is "self-determination," meaning that the process is entirely voluntary and noncoercive, such that the parties and counsel themselves maintain control throughout.

• The physician as neutral allows for objective review of the medical record through engagement of the patient advocates, assisting to winnow out claims that do not present reasonable grounds for compensation. This is sorely missing from the current process, where the battle of adversarial experts leads to arbitrary and unpredictable results.

• The professional nonphysician mediator guides a process further designed around what the parties really care about and need from a resolution, while the physician focuses on the medicine and the event of treatment. Claims present an array of legal, medical and emotional issues, above and below the surface. There may be various ways to resolve a claim other than through monetary compensation, such as acknowledgment of, and even apology for, error to satisfy the emotional needs of patients and their families. Also, providers, who are truly

interested in avoidance of error so as to improve safety and outcomes, have access to a process through which the opportunity for learning can become as important in certain cases as successful defense of a claim.

• Concern that two mediators increase expense are met by the overall cost saving that is a significant multiple of the cost of the mediation itself. The physician/mediator combination allows for high-quality substantive review within a well-designed and conducted interest-based mediation process. No one mediator can provide that blend of expertise and dynamism in medical cases to address and work through the complex mix of issues.

• Costs and time to resolution are reduced dramatically. The considerable waste in the present system can be all but eliminated for cases that opt in to this process, with the opportunity to opt out (and thus present no risk) in the unlikely event that the mediation does not produce the desired results. The court system is always a backstop.

Will all the players be willing to participate? That is a key question, the answer to which requires further exploration with them directly. The short answer is: only if their interests are definitively considered and met. In the case of patients, that means providing a process alternative to the enduring frustration of the courts that offers fair and prompt compensation for legitimate claims.

For medical providers, including hospitals which are increasingly employing physicians in the evolving health care landscape and are becoming self-insured, costs are reduced. Risk management and avoidance, which comes from understanding and addressing the cause of error, can become more proactive rather than defensive. As well, due to the rise of "outcomes-based" reimbursement in health care, balanced examination of the clinical merits of cases can lead to future error reduction and, hence, better outcomes.

Mediation with a neutral physician provides an opportunity for patients to engage positively, while being far more economical and decisive than the current system. While plaintiffs lawyers and defense counsel, whose clients' needs are served, should not be a significant impediment, we do have to address the reality that they often control the current process and need to be convinced about the opportunity for faster, effective resolution for their patient clients and ongoing satisfaction with the process and improved relationships with defense counsel's medical clients.

Any proposed solution to an intractable problem such as the current state of medical malpractice claims resolution is not a panacea. What we have outlined here, however, offers an opportunity for the parties to shape a voluntary process that eliminates the shortcomings of the present system, maintains party self-determination, and produces results that can address the concerns, and quiet the cries, of critics and reflexive reformers who could well regret what they otherwise create. •

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