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Medical Malpractice Mediation: A “Healthy” Resolution for Patients, Doctors and Insurance Companies

by Lee A. Rosengard and Marissa Parker

In a steadily growing trend, physicians are turning to pretreatment, predispute arbitration clauses to control their liability exposure to their patients. These clauses are advocated by physicians’ insurance providers, primarily through the lowering of premiums when doctors agree to secure predispute arbitration agreements with their

patients. These arbitration clauses force patients to waive either their right to trial or right to treatment, place doctors in an adversarial role upon meeting their patients for the first time, and do little to reduce legal costs for insurance companies arbitrating claims in a forum that increasingly mirrors



litigation. Insurers’ and doctors’ use of a pretreatment commitment to mediation, rather than binding arbitration, holds far more potential for medical malpractice stakeholders to control dispute-based costs, avoid frivolous litigation and resolve controversies that better satisfy all parties involved.

Mandatory binding arbitration denies access to court. It is commonly provided for in consumer agreements such as cell phone, rental car and credit card contracts. Advocates of binding arbitration suggest that lower costs, quicker resolutions and the absence of “runaway jury” verdicts are all advantages that participants gain by forgoing a jury trial. Whether these “advantages” truly exist for consumers is questionable. Regardless, they ignore the practical absence of consent: Whether the consumer reads the contract or not, its arbitration clause forecloses any opportunity to reach a courtroom.

Unlike cell phone and credit card contracts, the stakes involved in locking patients into binding medical malpractice arbitration are considerably higher. First, a patient may unknowingly sign away his or her right to trial in the haste to get medical attention. Second, if a patient wants to pursue a claim, he or she must pay

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significant filing costs and arbitration fees, which amount to thousands of dollars, simply to commence the process. Third, binding arbitration has exceedingly narrow grounds for appeal, rendering decisions largely final regardless of whether the evidence or law supports the outcome. Overall, the arbitration system is largely antithetical to the rights of the patient.

The stakes are high for doctors, too. In advocating the use of binding arbitration, insurers are primarily concerned with containing their exposure, which is managed foremost by settling cases.

Traditionally, when a doctor settles a malpractice case, a formal finding of negligence is registered in the National Practitioner Data Bank.

The finding then becomes a factor when medical boards, reviewers or insurers decide whether to extend privileges, grant licenses or issue an insurance policy to a physician.

While insurance carriers may push for settlement, doctors may not find themselves equally aligned – a formal finding of negligence against a physician can be emotionally and professionally devastating.

Statistically, as compared to medical malpractice litigation, arbitration yields lower monetary awards and routinely assigns higher rates of physician culpability and lower rates of compensation to patients. Put differently, the statistics show that no one really wins in arbitration.

Legal and medical professional organizations have advocated against pretreatment arbitration agreements, but their pronouncements have not stopped the practice. In 1998, the American Arbitration Association, American Bar Association and American Medical Association released a final report from the Commission on Health Care Dispute Resolution.¹ The concerns of due process and fundamental fairness to the participants prompted the

commission to recommend that “binding forms of dispute resolution should be used only where the parties agree to do so *after* a dispute arises.”²

Accordingly, the AAA will only administer individual patient medical malpractice cases if the arbitration agreement is entered into after the dispute arises.³ In doing so, the AAA “distinguish[es] a patient undergoing health care treatment from other situations involving an individual.”⁴

A parallel development that holds far more potential for systemic and societal benefits is the use of pretreatment commitments by patients and doctors to mediate – rather than arbitrate – any disputes that may later arise. Unlike arbitration, mediation is a

party-driven practice that requires true consent to arrive at a resolution, because a resolution must be agreed upon by the parties themselves. Even more important, mediation allows the parties to think broadly and incorporate creative elements into their agreements, enlarging the potential for parties to develop a mutually satisfying resolution. The complex world of medical science often precludes the existence of a clear-cut winner; even where a

doctor may have easily met the standard of care, the difficulty of explaining in court the complicated medicine involved may discourage doctors and lawyers from “gambling” on a jury. And unlike negotiated settlement talks held in the wake of an arbitration or litigation, where direct across-the-table participation by clients is rare, mediations open the door to participation by the real stakeholders in the controversy: the parties.

The mediation process allows a dialogue to develop that lends legitimacy to the stakeholders’ goals and to the ultimate resolution reached. For instance, if the ultimate cause of injury or death resulted from a fixable error in protocol, the plaintiff can request that the doctor and/or institution review and reform the protocol as a condition of the resolution. Conversely, a doctor who finds himself or herself embroiled in a

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In evaluating mediation as a method of resolution, it is important to view mediation as an alternative to, rather than a substitute for, a jury trial or arbitration.

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dispute with a seriously injured patient, whose injuries may have nothing to do with the doctor's conduct, has more control over whether a formal finding of negligence will be entered against him or her in the National Practitioner Data Bank. And the insurance company, always watching the bottom line, has a say in the amount of compensation paid out to the patient. Even if mediation awards reach seven figures, there is no "runaway jury" when the parties control and mutually agree to the award.

Of course, mediation is not a panacea. Like arbitration, mediation is private and does not create a written record. Accordingly, there cannot be any public vindication for any of the parties. Mediation also only works if the parties commit to the process. Several common perceptions present early obstacles in obtaining that commitment, such as the beliefs that plaintiffs can get more money in court, that the mediation process will be manipulated to one party's advantage or that agreeing to mediate is a sign of weakness. But those who trust in the process, and convince others to give it a try, recognize that mediation's strengths outweigh its weaknesses.

Additionally, in evaluating mediation as a method of resolution, it is important to view mediation as an alternative to, rather than a substitute for, a jury trial or arbitration. The tools and outcomes of each are vastly different, and both mediation and litigation/arbitration play significant, albeit different, roles in resolving medical-related conflicts. A key difference in parties making a commitment to first take their dispute to mediation, instead of arbitration, is that mediation can coexist with other forms of dispute resolution, while binding arbitration begins and ends with itself, demanding near-complete finality in its application.

Ultimately, the successful use of mediation in medical malpractice disputes between patients and providers depends upon buy-in. Buy-in comes from understanding the unique strengths of the mediation process, namely confidentiality, enhanced communication, cost-effectiveness and creative outcomes. Mediation in the medical malpractice arena will amass buy-in from doctors and insurers through successful personal experiences, anecdotal evidence and the social acceptance of mediation as an effective form of dispute resolution.

Recently, key institutions in Pennsylvania have endeavored to push mediation to the forefront of the medical malpractice arena. In 2003, Governor Edward G. Rendell began formally encouraging the use of mediation to solve the medical malpractice cases clogging Pennsylvania courts and driving up doctors' insurance rates. Contemporaneously, the state Supreme Court encouraged counties to look at litigation alternatives to curb the flight of doctors exiting Pennsylvania due to rising malpractice insurance rates, and formed the Medical Malpractice Task Force.

In a steadily growing trend, physicians are turning to pretreatment, predispute arbitration clauses to control their liability exposure to their patients.

In 2004, Philadelphia's Drexel University College of Medicine was the first institution in southeastern Pennsylvania to adopt a formal medical malpractice mediation program. Drexel's program offers parties a team consisting of a plaintiff and defense malpractice litigator acting together as co-mediators. The system attempts to balance the players by directing all costs to be paid by the defendants and allowing the plaintiff to pick both co-mediators.

In March 2008, after years of planning and deliberation initiated and sponsored by the Pennsylvania Medical Society, Abington (Pennsylvania) Memorial Hospital, the Montgomery County Medical Society and the Montgomery Bar Association launched a pilot project to mediate conflicts between patients and the hospital or its

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doctors. The unique two-phase program first uses Abington professionals trained in conflict management to intervene immediately after a clinical incident. For conflicts not resolved in Phase 1, the situation moves to Phase 2, which draws on members of Pennsylvania's Montgomery County Bar Association and Montgomery County Medical Society who have volunteered to be trained in mediation and to work in teams to mediate malpractice conflicts. The program is voluntary; patients never waive their right to trial and may be represented by counsel.

Notably, these leading institutions advocating medical malpractice mediation have not needed the blessing of their insurers. Drexel initiated this program when it became self-insured after its previous malpractice insurer pulled out of the medical malpractice insurance business. Abington's status as a self-insured facility was also cited as enabling it to commit to the mediation pilot program without first obtaining the approval of outside insurers.

Private insurers seem somewhat absent from the emerging movement toward mediating medical malpractice cases, but some have developed communication-based training and disclosure programs that share many of the principles underlying mediation. For instance, in 2000, COPIC, a malpractice insurance provider servicing approximately 6,000 Colorado and Nebraska physicians, created the 3Rs Program – Recognize, Respond, Resolve – to increase early intervention and resolution of malpractice claims. Physicians are trained to promptly disclose potential malpractice to program administrators. If a patient commits to this alternative-track resolution, the physician and administrators work together to engage in open dialogue to resolve the conflict. The 3Rs Program is “no fault,” meaning it does not tie compensation to evidence of fault on the provider's part. Additionally, patients do not waive their right to sue. COPIC's early intervention is working: of 4,600 qualifying incidents, only 953 resulted in patient reimbursements

(average of \$5,293 per paid incident), with only 28 of those 953 cases progressing to a formal lawsuit.

The economic and emotional gains that patients, doctors, hospitals and insurers have experienced from disclosure programs could be further enlarged by adopting full-scale mediation programs. By turning away from arbitration and adopting organization-wide mediation programs or implementing incentives for doctors to use pretreatment commitments, industry can expedite reduced malpractice insurance costs and encourage better quality health care overall. With no limit to the types of conflicts resolvable and potential solutions achievable, mediation holds the most hope for comprehensive nationwide treatment of medical malpractice disputes and cost-efficiency in the health care arena. ■

¹ FINAL REPORT: COMMISSION ON HEALTH CARE DISPUTE RESOLUTION (hereinafter “1998 REPORT”), July 27, 1998, available at <http://www.adr.org/sp.asp?id=28633> (last visited July 9, 2008).

² 1998 REPORT, *supra* note 29, Section XII.C, Principle 3 (emphasis added).

³ *AAA Healthcare Policy Statement*, available at <http://www.adr.org/sp.asp?id=32192> (last visited July 9, 2008). AAA will administer cases in the health care area where business, providers, health care companies or other entities are involved on both sides of the dispute. *Id.*

⁴ *Id.*



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Review of Recent Arbitration Decisions

by Kevin R. Casey

Dealer Computer Services Inc. v. Old Colony Motors Inc.

The parties entered into contracts providing that disputes would be resolved under the Commercial Arbitration Rules of the American Arbitration Association and that the AAA would conduct the arbitration. As part of the arbitration, the AAA required Old Colony to deposit its share of money for the final hearing. Old Colony advised that it could not afford to pay (although Old Colony had asserted affirmative claims in addition to defenses). The arbitrators asked Dealer Services to pay the full deposit; Dealer Services refused. Under AAA Rules 52 and 54, the arbitration panel indefinitely suspended the proceedings.

Dealer Services sued under 9 U.S.C. § 4 in federal district court to compel Old Colony to pay the deposit, and the district court so ordered. The Ninth Circuit Court of Appeals reversed, holding “Dealer Services’ remedy lies with the arbitrators.” The appellate court cited and applied *Howsam v. Dean Witter Reynolds, Inc.* (absent an agreement to the contrary, the parties intend that the arbitrator, not the courts, should decide certain procedural questions that grow out of the dispute and bear on its final disposition). Payment of fees is a procedural condition precedent, set by the AAA in Rule 52, that the trial court should not review. The arbitrators are within their discretion to ask one or the other party to pay the entire fee and tax the fee as part of the award, or, alternatively, suspend the arbitration. AAA Rule 54. The Ninth Circuit concluded, “the solution may not be totally satisfactory, but it preserves the flexibility and discretion in the hands of the arbitrators, a policy end the [Federal Arbitration Act] favors.”



***PMA Capital Insurance Co. v. Platinum Underwriters Bermuda* (on appeal to the U.S. Court of Appeals for the Third Circuit)**

In 2003, PMA (a Pennsylvania insurance company) and Platinum (a Bermuda reinsurance company) entered into a reinsurance contract. The contract permitted Platinum to seek, in certain circumstances, reimbursement for previously incurred losses that it could “carry forward” (Deficit Carry Forward Provision). The contract also included an arbitration provision that directed the arbitrators to “interpret this Agreement as an honorable engagement and not merely as a legal obligation. They are relieved of all judicial formalities and may abstain from following the strict rules of law. They will make their award with a view to effecting the general purpose of the Agreement in a reasonable manner rather than in accordance with the literal interpretation of the language” (Honorable Engagement Provision).

A dispute arose about the validity and scope of the Deficit Carry Forward Provision, and arbitration ensued. The arbitration panel issued a one-page award that required PMA to pay Platinum \$6 million and removed from the contract all references to the Deficit Carry Forward Provision. Perhaps as requested by the parties, the award did not include reasons or explanation.

PMA asked the district court to vacate or, in the alternative, to modify the arbitration award. The district court noted the great deference given to arbitration awards. The Federal Arbitration Act expressly allows vacatur “[w]here the arbitrators exceeded their powers.” The court vacated the award, finding that the relief was not sought by either party; contravened the contract that the panel was charged

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with interpreting; and wrote out of existence a key contract provision. Based on these findings, the award could not be “rationally derived” from either the agreement (despite the Honorable Engagement Provision) or the parties’ submissions. Because it did not “draw its essence” from the contract, but rather was “in manifest disregard thereof,” the award was “completely irrational.” The court also noted that “evaluation of the Arbitrators’ decision was made more difficult by their failure to offer any supporting explanation or reasoning.”



In re Arbitration Between Wells Fargo Bank, N.A. and WMR e-PIN, LLC (now on appeal to the U.S. Court of Appeals for the Eighth Circuit)

One of Wells Fargo’s subsidiaries entered a patent license agreement with WMR e-PIN, LLC. The agreement included a license, a covenant not to sue and an arbitration provision. Pursuant to the latter, arbitration was conducted and an award issued. Wells Fargo sued in district court to correct the arbitration award and to confirm the award as corrected. WMR moved to vacate or modify the award. In a Report and Recommendation dated June 22, 2009, a U.S. magistrate judge recommended that Wells Fargo’s motions be granted and that WMR’s motions be

denied. The district court adopted the Report and Recommendation.

The district court held that WMR waived its right to object to the arbitration panel’s award of injunctive relief by requesting injunctive relief from the panel. WMR also waived its right to claim that the panel lacked the authority to award attorney fees by requesting an award of fees. The panel nevertheless did not exceed its authority by awarding fees to Wells Fargo as the prevailing party. Consideration of the argument that the fee award was improper because of the public disclosure of trade secrets was denied. The doctrine of “manifest disregard,” an extra-statutory ground to vacate an arbitral award, was no longer a viable basis for vacatur. The arbitration panel made the finding on patent inventorship to decide the claims of trade secret misappropriation; the parties’ dispute regarding ownership of the trade secrets turned on competing claims of inventorship. ■



Kevin R. Casey

If you have questions regarding these decisions or would like more information, please contact Kevin R. Casey at 610.640.5813 or kcasey@stradley.com.

Stradley Ronon At Work

Lee Rosengard, Kevin Casey and Ben Picker participated in the Annual Meeting of CPR: International Institute for Conflict Resolution and Prevention, in New York City. Keynote Speakers were Kenneth R. Feinberg, Obama Administration Compensation Czar, and Professor Richard Susskind, author of “The End of Lawyers?”

Ben Picker has been certified as a mediator by the newly founded International Mediation Institute (IMI) headquartered in Hague, Netherlands. The

IMI was created to certify high competency standards of mediators throughout the world and in order to provide users with detailed information concerning mediator’s style and level of experience.

Ben Picker has authored an article entitled “Preparation: The Key to Successful Outcomes in Mediation.” The article appeared in the February, 2010, edition of Alternatives, CPR’s monthly publication.

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At Stradley Ronon, our lawyers are committed to exploring alternative dispute resolution whenever possible and making it an integrated part of our practice. The firm's ADR Practice Group consists of 14 lawyers who are specially trained in developing systems to avoid disputes and using ADR options to resolve disputes, including the following:

- ADR Audits
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- ADR Education and Training
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- Employment ADR
- Dispute Resolution Strategies
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