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# ASSESSMENT AND PLAN FOR MEDICAL MALPRACTICE: QUALITY IMPROVEMENT THROUGH MEDIATION

*Douglas W. Taylor\**

## INTRODUCTION

Medical errors occur at an alarming rate. In 1990, Harvard Medical School in conjunction with medical record administrators, as well as board-certified physicians and nurses, conducted *The Harvard Medical Practice Study* (HMPS) in New York.<sup>1</sup> The purpose of the study was to investigate and examine the incidence of injuries resulting from medical interventions or “adverse events.”<sup>2</sup> The study involved a sample of more than 31,000 New York hospital records drawn from the year 1984.<sup>3</sup> The study utilized medical record administrators and nurses in the screening phase, and board certified physicians in the physician-review phase.<sup>4</sup>

The HMPS analyzed 30,121 (96%) of the 31,429 records selected for the study sample.<sup>5</sup> After preliminary screening, physicians reviewed 7,743 records, from which a total of 1,133 adverse events were identified that had occurred as a result of medical management within the hospital or required hospitalization for treatment.<sup>6</sup> Of this group, 280 were judged to have resulted from negligent care.<sup>7</sup> Weighing those figures in accordance with the sample plan, they concluded the

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<sup>1</sup> Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York, THE REPORT OF THE HARVARD MEDICAL PRACTICE STUDY TO THE STATE OF NEW YORK (1990) at 3-1, 3-3 [hereinafter HARVARD MEDICAL PRACTICE STUDY].

<sup>2</sup> *Id.* at Executive Summary, at 1.

<sup>3</sup> *Id.* at 4-1.

<sup>4</sup> *Id.* at 5-4, 5-5.

<sup>5</sup> *Id.* at 6-1.

<sup>6</sup> HARVARD MEDICAL PRACTICE STUDY, *supra* note 1, at 6-1.

<sup>7</sup> *Id.*

incidence of adverse events for hospitalizations in New York in 1984 to be 3.7%, or a total of 98,609 cases.<sup>8</sup> Of these, they concluded that 27.6%, or 27,179 (or 1% of all hospital discharges) were due to negligence.<sup>9</sup>

This study was able to elucidate a number of facts about negligence and malpractice worth mentioning. First, it provided concrete evidence that, although relatively rare, adverse events are occurring at a significant rate in the American health care system.<sup>10</sup> Furthermore, although the study showed a clear association between adverse events and medical negligence, it was far from one hundred percent.<sup>11</sup>

Between 2,967 and 3,888 patients during the study year filed malpractice claims.<sup>12</sup> The investigators of this study were able to use these numbers, compared with the projected statewide number of injuries from medical negligence during the same period, to conclude that: one out of every eight injuries due to negligence resulted in a malpractice claim.<sup>13</sup> They went on to conclude that only half of the patients who filed malpractice claims received compensation via the current tort-liability system.<sup>14</sup>

By nature, the average American citizen desires and expects excellence from the health care provided in our country. The truth is that while we do excel in many areas of medicine, there are areas in which our system is still prone to mediocrity. The areas of concern that will be discussed in this comment are that of legal liability and malpractice action. The intention is to discuss the evolution and purpose of the malpractice system, to analyze the effectiveness of the system in achieving its purpose, and to explore avenues of improving the American health care system outside of malpractice.

## MEDICAL MALPRACTICE: HISTORY AND PURPOSE

The data from the study above reveal that the practice of medicine is an imperfect science.<sup>15</sup> The fact that doctors and researchers are

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<sup>8</sup> *Id.* at 6-9.

<sup>9</sup> *Id.*

<sup>10</sup> *Id.* at 6-1.

<sup>11</sup> HARVARD MEDICAL PRACTICE STUDY, *supra* note 1, at 6-1.

<sup>12</sup> *Id.* at 7-1.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> *Id.* at 6-1.

continuously searching for better ways to treat and prevent disease is a testament to the imperfect nature of medicine. Not only is medicine itself imperfect, but the people that administer and deliver care to the patient are also not without limitations of their own. Physicians and hospital staff are normal people who are subject to the cruelties and deficiencies of life as are all humans. Such a condition of imperfection makes the existence of mistakes inevitable.

Mistakes in medicine are made not only by physicians, but also by nurses, hospital staff, Health Maintenance Organization (HMO) administration, and others.<sup>16</sup> Patient injuries oftentimes result from these mistakes and are an undesirable outcome of too many instances of health care delivery in this country. It is not a stretch to say that injuries offer a serious threat to the injured party and society as a whole. Injured patients many times lose income through work absences, pay additional medical costs, and suffer excruciating pain and emotional anguish. Society is also burdened as the country suffers a loss of production due to loss of time at work, compensates non-insured patients through public assistance, and pays in the form of escalating insurance premiums for those who are insured.

Medical malpractice law was instituted to offer the patient a method of compensation for injuries stemming from medical mistakes and to deter health care providers from negligent behavior. The law states that when a medical malpractice claim is filed, in order to win the case the plaintiff must satisfy a set of conditions.<sup>17</sup> These conditions are common to all malpractice claims and include: 1) establishing the standard of care through expert testimony, 2) proving that the defendant failed to provide that level of care, and 3) showing that the defendant's lack of skill caused the injury to the plaintiff.<sup>18</sup> The Supreme Court of Texas defined the generally accepted definition of "standard of care" by stating: "A physician who undertakes a mode or form of treatment which a reasonable and prudent member of the medical profession would undertake under the same or similar circumstances shall not be subject to liability for harm caused thereby to the patient."<sup>19</sup>

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<sup>16</sup> See Gary Vogin, M.D., *Medical Mistakes: As a Result of a Medication Error, the Writer Suffered a Stroke. Could This Happen to You?*, (Nov. 21, 2001), at [http://content.health.msn.com/content/article/11/1691\\_50518.htm](http://content.health.msn.com/content/article/11/1691_50518.htm).

<sup>17</sup> DAN B. DOBBS & PAUL T. HAYDEN, *TORTS AND COMPENSATION* 334 (3d ed., West Publishing Co. 1997).

<sup>18</sup> *Id.*

<sup>19</sup> *Henderson v. Heyer-Schulte Corp. of Santa Barbara et al*, 600 S.W.2d 844, 847 (Tex. Civ. App. 1980).

Establishing and relying on the standard of care for each medical malpractice action however, is fraught with difficulties.<sup>20</sup> Due to the variable nature of medicine, there is no actual national standard of practice for many medical treatments and procedures.<sup>21</sup> That the legal community has recognized and implemented a means of working around this problem is proven by the existence of the “respectable minority” rule.<sup>22</sup> This rule “serves as an accommodation for the exercise of clinical judgment, holding that ‘a physician does not incur liability merely by electing to pursue one of several recognized courses of treatment.’”<sup>23</sup> Without indulging in a more in-depth analysis of all the specifics pertaining to the definition of standard of care, it is sufficient for my purposes here to recognize it as a very complicated issue in which the function of clinical guidelines has yet to be fully played out.

There is in fact quite a long history of medical malpractice in this country.<sup>24</sup> Court cases deliberating patient injuries linked to negligent acts of health care professionals are documented as far back as the early years of American history.<sup>25</sup> In the case of *Cross v. Guthery* in 1794, the court allowed a husband to sue a surgeon for “unskillful, ignorant, and cruel” surgery which ultimately led to his wife’s death.<sup>26</sup> However, a major increase in the frequency of malpractice claims did not occur until the 1930s, coming to a nadir in the 1970s.<sup>27</sup>

Medical care is obviously delivered today in a much different way than it was in the past. It was not until the early 1900s that the hospital came to be a common way to receive medical care.<sup>28</sup> Before then, physicians were used to making house calls, treating the sick in their own homes, and only dedicating a very small portion of their time

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<sup>20</sup> See Roger N. Braden & Jennifer L. Lawrence, *Medical Malpractice: Understanding the Evolution - Rebuking the Revolution*, 25 N. KY. L. REV. 675, 683-84 (1998).

<sup>21</sup> *Id.*

<sup>22</sup> See James F. Blumstein, L.L.B., *The Legal Liability Regime: How Well Is It Doing In Assuring Quality, Accounting for Costs, and Coping with an Evolving Reality in the Health Care Marketplace?*, 11 ANN. HEALTH L. 125, 133 (2002).

<sup>23</sup> *Id.* (citing *Downer v. Veilleux*, 322 A.2d 82, 87 (Me. 1974)).

<sup>24</sup> See Braden & Lawrence, *supra* note 20, at 693.

<sup>25</sup> See *id.*

<sup>26</sup> *Cross v. Guthery*, 1794 Conn. App. LEXIS 20, at \*1 (Conn. 1794).

<sup>27</sup> See Jason Leo, *Torts – Medical Malpractice: The Legislature’s Attempt to Prevent Cases Without Merit Denies Valid Claims*, *Lindberg v. Healthier Partners, Inc.*, 27 WM. MITCHELL L. REV. 1399, 1402 (2000) (citing Shirley Qual, *A Survey of Medical Malpractice Tort Reform*, 12 WM. MITCHELL L. REV. 417, 420-21 (1986)).

<sup>28</sup> See Braden & Lawrence, *supra* note 20, at 678.

to hospital work.<sup>29</sup> As hospitals and Health Maintenance Organizations (HMOs) grew into their new role in the system of health care, they naturally took on a large amount of responsibility for the effectiveness of the care that they delivered and the negligence of their employees.<sup>30</sup>

Health care institution liability covers three general areas.<sup>31</sup> First is a failure to ensure a safe environment for the delivery of health care.<sup>32</sup> Second is the failure to train and supervise nurses and staff.<sup>33</sup> Third is the failure to establish measures for patient safety through hospital procedures and protocols.<sup>34</sup> HMOs have been found liable for negligence in selecting, retaining, monitoring and evaluating physicians and personnel.<sup>35</sup> HMOs are also liable for negligence in the selection and retention of health care facilities.<sup>36</sup> Recent legislation in Texas and Missouri resulted in legislation which provides that patients may sue their HMOs directly if the HMO fails to use "ordinary care" when deciding whether or not it should pay for a medical procedure.<sup>37</sup> It is thought that other states will follow suit which will cause HMOs to be judged by the same standards of care expected of individual physicians.<sup>38</sup>

### QUESTIONING EFFECTIVENESS IN PATIENT COMPENSATION AND DETERRENCE OF NEGLIGENCE

Medical Malpractice litigation is not sufficiently effective in achieving its goals of patient compensation and deterrence of negligence in the health care setting.<sup>39</sup> In fact, in research for this publication I found it very difficult to locate anyone, including patients, physicians, insurance representatives, and even litigators for that matter, who is happy with the medical malpractice system. There are many reasons why this is so, and a few will be discussed here.

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<sup>29</sup> *See id.*

<sup>30</sup> *See id.* at 679.

<sup>31</sup> *Id.* at 681.

<sup>32</sup> *Id.*

<sup>33</sup> *See* Braden & Lawrence, *supra* note 20, at 681.

<sup>34</sup> *Id.*

<sup>35</sup> *Id.* at 690.

<sup>36</sup> *Id.*

<sup>37</sup> *Id.* at 692.

<sup>38</sup> *See* Braden & Lawrence, *supra* note 20, at 693.

<sup>39</sup> *See infra* text accompanying notes 40-59.

First, it is evident that by current standards, the medical malpractice system is not sufficiently compensating the patient-victims who suffer injuries due to negligent acts.<sup>40</sup> By analyzing the results of the Harvard Medical Practice Study listed above, it is readily apparent that the patients who *are* able to navigate the system, get their claims filed, try their case in the courtroom, win their case, and receive compensation for their injury, are a very small minority of the patients who are injured due to negligence.<sup>41</sup>

I recently attended the DePaul Journal of Health Care Law Symposium (Symposium) where Robert Clifford and E. Michael Kelly, both prominent figures in the practice of medical malpractice cases in Chicago as Plaintiff's Counsel and Defense Counsel respectively, were united in their estimation of a minimum cost of \$150,000 to \$250,000 to adequately represent a client in court for a medical malpractice claim.<sup>42</sup> Panelists at the Symposium concluded that such a cost was certainly limiting the types of cases filed, such that only those cases that were more likely to be awarded large amounts of compensation were ever given the opportunity to be taken to trial.<sup>43</sup>

Troyen Brennan, a professor of Law and Public Health at Harvard University, performed follow-up studies on the patients enrolled in the HMPS and concluded that patients' likelihood of winning a suit was directly related to how severe their adverse outcome had been.<sup>44</sup> The results of the study also showed that of the relatively small number of patients who filed claims and went to court to try those claims, half of them went away empty-handed.<sup>45</sup> I submit that in these instances of uncompensated injury, the tort liability system causes patient-victims to undergo an additional traumatic loss, namely a costly (both emotional and monetary) loss in the courtroom, which serves only to further complicate their lives on a long-term basis. This of course is a

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<sup>40</sup> See HARVARD MEDICAL PRACTICE STUDY, *supra* note 1, at 7-1. Only 1/16 of the patients injured by negligent acts actually received compensation through the tort litigation system. *See id.*

<sup>41</sup> *See id.*

<sup>42</sup> DePaul Journal of Health Care Law, Symposium, *Medical Malpractice: Innovative Applications, Panel 2: Anatomy of a Malpractice Case from a Litigator's Perspective*, Feb. 21, 2003 (forthcoming publication, 6 DEPAUL J. HEALTH CARE L. 279 (2003)).

<sup>43</sup> *Id.*

<sup>44</sup> Troyen Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1966 (1996).

<sup>45</sup> See HARVARD MEDICAL PRACTICE STUDY, *supra* note 1, at 7-1.

predictable outcome of the tort system itself, which addresses issues of physical injury in absolute terms of right and wrong.

Under tort law, if it is proven in court that the injury was wrongfully caused, monetary compensation must be paid by the wrongdoer.<sup>46</sup> However, if the harm caused by the defendant was done in the absence of any legal wrongdoing, the plaintiff will be forced to go home uncompensated.<sup>47</sup> In the latter instance, of course, there are no concessions made for the severity or the permanence of the injury incurred by the plaintiff.<sup>48</sup> It can be seen then just how this costly process can end up leaving the uncompensated injured patient in a much worse condition than before. It is also important to recognize that these costs are not borne on a strictly individual basis, and become a significant source of much social concern.

The deterrent function of the law of torts is also flawed. In theory, by requiring that the monetary compensation awarded to the plaintiff be paid by the remiss health care professional, bystanders of the medical profession will take notice and be aware that similar acts of negligence will require mandatory payments; hence, this financial danger will cause them to avoid such an indiscretion.<sup>49</sup> This is the two-part theory of compensation and deterrence, believed in by so many lawyers, which garners different results in the theoretical realm than in that of reality.<sup>50</sup> I argue that its major flaw is also one of its chief principles: the doctrine that punishment serves as a successful form of deterrence of human error.

Dr. Brennan's studies involving the HMPS patients have failed to show any evidence that medical malpractice suits are effective in reducing the number of medical injuries suffered by patients secondary to negligent acts of the health care community.<sup>51</sup> In reality, there is much more evidence to the contrary. Recent trends have shown a very disturbing linkage of increased medical error rates and the malpractice litigation process itself.<sup>52</sup> Two independent researchers, Thomasson and Passineau, demonstrated evidence that physicians against whom a malpractice claim was pending suffered from an increased probability

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<sup>46</sup> DOBBS & HAYDEN, *supra* note 17, at 3.

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> 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, 295 (2000).

<sup>50</sup> *See id.*

<sup>51</sup> HARVARD MEDICAL PRACTICE STUDY, *supra* note 1, at 10-39.

<sup>52</sup> Dauer, *supra* note 49, at 298.

of committing another error within the year following the filing of the first claim.<sup>53</sup>

One of the reasons why litigation does not reduce the rate of medical error is that it causes the physicians under review to undergo a greater amount of self-doubt and puts them under psychological strain which hinders their performance.<sup>54</sup> Atul Gawande, a physician and author, wrote about his conversation with a well-respected surgeon who lost control of a patient's bleeding while removing a benign tumor.<sup>55</sup> After the patient died from his negligence, this prominent surgeon admitted to becoming "tentative and indecisive" in the operating room and that the case negatively affected his performance "for months."<sup>56</sup> The physicians that undergo the malpractice review process feel a large amount of stress which leads them to alter their behavior in detrimental ways, which then may lead to a higher probability of errors.<sup>57</sup> Lucian Leape, one of medicine's leading experts on error, stated that "... fear, reprisal, and punishment produce not safety, but rather defensiveness, secrecy, and enormous human anguish."<sup>58</sup> It is the tort system itself that posits the patient and physician as adversaries completely eliminating any chance that the two parties could acknowledge adverse outcomes and discuss them openly.<sup>59</sup>

### MEDIATION AS A FORCE FOR PATIENT SATISFACTION AND QUALITY IMPROVEMENT

I propose that an organized system of mediation would be the best alternative to the current medical malpractice system for several reasons. It would help avoid the large jury verdicts in medical malpractice actions, the extravagant time and expense lost in court adjudication, the denial of compensation for the patient-victims whose case "worth" does not surpass the trial threshold and hence are too

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<sup>53</sup> *Id.* at 298 (citing Thomasson et al., *Patient Safety Implications of Medical Malpractice Claimed Resolution Procedures*, in PROCEEDINGS OF ENHANCING PATIENT SAFETY AND REDUCING ERRORS IN HEALTH CARE (1998)).

<sup>54</sup> See ATUL GAWANDE, *COMPLICATIONS: A YOUNG SURGEON'S NOTES ON AN IMPERFECT SCIENCE* 61 (Metropolitan Books Henry Holt & Co. 2002).

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> See generally Sara C. Charles, M.D. et al., *Sued and Nonsued Physicians Self-reported Reactions to Malpractice Litigation*, 142:4 AM. J. PSYCHIATRY 437, 437-40 (1985).

<sup>58</sup> Donald Berwick & Lucian Leape, *Reducing Errors in Medicine*, 319 BRIT. MED. J. 136 (1999).

<sup>59</sup> GAWANDE, *supra* note 54, at 57.

costly to prosecute, and the emotional trauma of litigation to both parties. It would also allow for an increase in the quality of decision makers and experts to be involved in the process. This makes possible the opportunity for the health care community to more openly address the source of medical errors, implement better means to eliminate avoidable errors, and to come forward and talk to the patient openly about mistakes. This type of approach would be much more successful in achieving patient satisfaction and improved quality of care, due to the eradication of the adversarial relationship of the tort system and the defensiveness, secrecy and general feeling of opposition that it encourages. Instead, it would allow the health care profession to appropriately interpret medical mistakes as opportunities to learn and improve their system of health care delivery.

Max Douglas Brown, General Counsel for Rush-Presbyterian-St. Luke's Medical Center in Chicago, spoke at the DePaul Journal of Health Care Law Medical Malpractice Symposium, and began by quoting the Chicago Lawyer which stated that the total medical malpractice settlements in the year 2002 for the city of Chicago was \$334 million.<sup>60</sup> He went on to state that on the basis of fundamental laws of economics, it would be impossible for such a system to continue to extract this inordinate amount of money from a single jurisdiction like Cook County.<sup>61</sup> The system would fail, he claimed, because with these monetary losses year after year, it would not be long before one or more of the major hospitals would be forced to close down, and the county would be left with inadequate health care services for its population.<sup>62</sup> It was with this type of economic foresight back in 1995, that Mr. Brown and his colleagues at Rush-Presbyterian-St. Luke's Medical Center decided to establish a mediation program to handle the constant stream of medical malpractice cases that funneled through their jurisdiction.<sup>63</sup>

Their mediation program consists of well-respected plaintiff's attorneys and defense attorneys trained in the practice of mediation at

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<sup>60</sup> DePaul Journal of Health Care Law, Symposium, *Medical Malpractice: Innovative Applications, Panel 1: Alternative Dispute Resolution Strategies in Medical Malpractice*, Feb. 21, 2003 (forthcoming publication, 6 DEPAUL J. HEALTH CARE L. 249 (2003)) [hereinafter *Malpractice Symposium, Panel 1*].

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

<sup>63</sup> *Id.*

Loyola University's Institute for Health Law.<sup>64</sup> When a case of voluntary mediation arises, the plaintiff chooses two mediators, one from each panel.<sup>65</sup> Prior to the mediation, the parties submit statements of the facts, descriptions of the injuries, and other relevant information.<sup>66</sup> The usual process is that the parties present an opening statement, and then they meet separately with the mediators, and then reconvene to conclude the negotiations.<sup>67</sup> Due to their experience with similar cases over the years, the mediators have been able to settle typical cases in four or five hours' time.<sup>68</sup> These settlements have occurred even in complicated cases and have provided a forum for healing for both of the parties involved.<sup>69</sup> In fact, in the estimation of Mr. Brown and those who have worked with him for the past eight years, they have provided a forum for the settlement and resolution of many cases that most likely would not have gone to court due to the excessive costs and risks involving a court trial.<sup>70</sup>

Max Brown and his associates are not alone as they are searching for an alternative and effective method for resolving disputes over iatrogenic injury within the American health care setting.<sup>71</sup> The Board of Registration in Medicine of Massachusetts, in conjunction with the Program for Health Care Negotiation and Conflict Resolution, conducted a pilot project called the Voluntary Mediation Program very similar to that described above.<sup>72</sup> The results of the study showed that "of the ten complaints mediated between 1993 and 1996, nine were successfully resolved, only four with monetary transfers."<sup>73</sup> It is not only the skyrocketing medical malpractice awards threatening the closure of hospitals that is sparking these new investigations, but the congested court systems, the aforementioned practice of "defensive medicine," the decrease in health care quality that has been

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<sup>64</sup> Ann Nevers, *Medical Malpractice Arbitration in the New Millennium: Much Ado about Nothing?*, 1 PEPP. DISP. RESOL. L.J. 45, 89 (2000).

<sup>65</sup> *Id.*

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> Nevers, *supra* note 64, at 89.

<sup>69</sup> Malpractice Symposium, Panel 1, *supra* note 60.

<sup>70</sup> *Id.*

<sup>71</sup> Kathy L. Cerminara, *Contextualizing ADR in Managed Care: A Proposal Aimed at Easing Tensions and Resolving Conflict*, 33 LOY. U. CHI. L.J. 547, 557 (2002).

<sup>72</sup> *Id.*

<sup>73</sup> *Id.* (quoting 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, 201-11(1997)).

demonstrated among those professionals under review for malpractice, and also the lack of therapeutic benefit felt by both parties in the current system.<sup>74</sup>

Mediation is a form of alternative dispute resolution that focuses on the basic interests of the parties involved and tends to de-emphasize their legal entitlements.<sup>75</sup> Mediation can be described to be the least adjudicatory of the alternative dispute resolutions and is in fact completely consensual, its nature being that of assisted negotiation and resulting in definitive resolution of a dispute only if the parties agree.<sup>76</sup> Essentially, mediation then becomes a facilitated negotiation in which parties are able to discuss their dispute with the help of a neutral yet experienced third party, whose role is to guide the discussion to cover the relevant issues, and most importantly to help the two parties communicate with one another.<sup>77</sup> Mediation is sometimes referred to as "facilitated negotiation," and unlike other forms of arbitration, the parties decide how they will resolve the dispute.<sup>78</sup>

Some of the benefits of mediation are obvious. The first immediate benefit is that of less expense. The mediation system at Rush-Presbyterian-St. Luke's Medical Center mentioned above is able to boast an average cost of \$5,000 per settlement.<sup>79</sup> This is in stark contrast to a jury trial that may last weeks and would come at a considerably higher cost.<sup>80</sup> Disputes are typically resolved in much less time in mediation than compared to the current system of tort litigation, which also adds to the money saved in attorney's fees and other out-of-pocket expenses.<sup>81</sup> The mediation process also avoids inflated jury verdicts based on arbitrary standards of decision (this is done through the use of experienced and knowledgeable mediators who know the important facts of a case), and, because it tends to resolve disputes

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<sup>74</sup> Ellen Waldman, *Substituting Needs for Rights in Mediation: Therapeutic or Disabling?*, 5 PSYCH. PUB. POL. & L. 1103, 1104 (1999).

<sup>75</sup> *Id.* at 1106.

<sup>76</sup> Cerminara, *supra* note 71, at 556-57.

<sup>77</sup> Scott Forehand, *Helping the Medicine Go Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation*, 14 OHIO ST. J. ON DISP. RESOL. 907, 919 (1999).

<sup>78</sup> Nevers, *supra* note 64, at 87.

<sup>79</sup> *Id.* at 89.

<sup>80</sup> *Id.*

<sup>81</sup> Forehand, *supra* note 77.

“once and for all,” it also serves to avoid the continued disputing so often seen in court adjudication.<sup>82</sup>

The benefit of avoiding court adjudication for both parties cannot be overstated. For the seriously injured patient, sitting through a long court trial is challenge enough, but add to that the time away from work, the worry of unpaid medical and legal bills, the possibility of losing the case, and one begins to understand the trauma of a court trial.<sup>83</sup>

On the defendant side of the coin, the physicians often perceive a negligent claim as a form of vilification, and must endure prolonged criticism and threat to their professional existence and financial security.<sup>84</sup> It can be seen then, how the privacy of the mediation forum and the rapidity with which these cases can be dealt with in fairness are particularly attractive to both parties.

This open forum of discussion offers the opportunity to the plaintiff to personally communicate dissatisfaction with the care received, and receive monetary and non-monetary compensation, as they are able to forge an agreement that includes incentives to preclude further medical negligence.<sup>85</sup> Following along the same line of argument, mediation outperforms litigation in maintaining the doctor-patient relationship by maximizing the opportunity for open communication.<sup>86</sup> The group at Rush-Presbyterian-St. Luke’s Medical Center was happy to report that in many instances in the mediation process, the defendant was able to apologize to the plaintiff, which provided a significant amount of healing and plaintiff satisfaction.<sup>87</sup> This speaks to the therapeutic quality of mediation which has the potential to foster feelings of trust and respect, or it may help the two parties to part ways in a manner that is relatively less harmful than the traditional adversarial relationship.

A potentially large long term benefit of mediation is the enormous potential for quality improvement in the American system of health care. Mediation would provide a forum for discussion and analysis of medical errors, which would allow the medical community to detect

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<sup>82</sup> David Zukher, Note, *The Role of Arbitration in Resolving Medical Malpractice Disputes: Will a Well-Drafted Arbitration Agreement Help the Medicine Go Down?*, 49 SYRACUSE L. REV. 135, 153-54 (1998).

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> Nevers, *supra* note 64, at 88.

<sup>86</sup> Forehand, *supra* note 77, at 921.

<sup>87</sup> Medical Symposium, Panel 1, *supra* note 60.

patterns of avoidable error in order to put in place mechanisms for quality improvement. Such patterns of error were detected in the HMPS, which reported higher incidences of adverse events due to negligence within two distinct patient populations: those over the age of 65, and those of poor ethnic minority status.<sup>88</sup>

Some additional research efforts focused on pinpointing causes for these patterns of mistakes could lead to effective measures to decrease the rate of medical errors. That this can be done was proven back in the 1970's by Ellison (Jeep) Pierce, Vice President of the American Society of Anesthesiologists, and Jeffrey Cooper, Engineer and author of a 1978 paper entitled "Preventable Anesthesia Mishaps: A Study of Human Factors."<sup>89</sup>

Pierce and Cooper were able to recognize through a thorough analysis of errors by anesthesiologists how equipment and behavior patterns were contributing to medical mistakes.<sup>90</sup> Pierce and Cooper successfully recognized the most common type of error in anesthesia: the maintenance of the patient's respiratory function.<sup>91</sup> They also found that the most dangerous moments of the general anesthesia process occurred after the patient was fully anesthetized and the physician's "vigilance waned."<sup>92</sup>

Pierce and Cooper additionally found that the anesthesia equipment's poor design was also leading to medical errors.<sup>93</sup> They discovered these patterns of error through frank discussions with physicians interested in quality improvement and careful investigation of the equipment and conditions they were working in.<sup>94</sup> Finally, Pierce and Cooper were able to implement controls and checkpoints to further ensure maintenance of each patient's airway, increase physician vigilance throughout the anesthesia process, and correct the poor design of the anesthesia equipment.<sup>95</sup> Their work proved highly successful in decreasing the number of deaths related to general anesthesia, and improving the overall practice of anesthesia.<sup>96</sup> This should serve as a model for other branches of medicine to follow. The practice of

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<sup>88</sup> HARVARD MEDICAL PRACTICE STUDY, *supra* note 1, at 6-23, 6-24.

<sup>89</sup> GAWANDE, *supra* note 54, at 65.

<sup>90</sup> *Id.* at 66-67.

<sup>91</sup> *Id.* at 66.

<sup>92</sup> *Id.*

<sup>93</sup> *Id.* at 65-66.

<sup>94</sup> GAWANDE, *supra* note 54, at 66.

<sup>95</sup> *Id.* at 67.

<sup>96</sup> *Id.* at 68.

mediation to resolve disputes due to medical errors will allow for this type of improvement to happen on a more regular basis.

### CONCLUSION

Mediation conceived in this manner is feasible and would allow the plaintiff and defendant to escape from the medical malpractice system and focus on the basic needs and interests of both parties. As a prospective member of the medical professional community, I am constantly amazed at the work rate and unselfishness of my physician mentors. I know that there are very few medical professionals whose motives are not totally pure, but they are a relatively insignificant handful compared to the hundreds and thousands whose primary interest is to practice good, sound medicine and help those around them enjoy good health. I also trust in the good intentions of patients, who deserve to be compensated in the event that a negligent act should cause them harm.

The mediation process, unlike the traditional system of tort litigation, would allow plaintiffs and defendants to address one another early when a mistake leads to an injury during the receipt of medical care in an open and direct manner. This setting would have the potential to result in both monetary and non-monetary compensation to the patient, and would lend itself to a more in-depth investigation of medical errors for quality improvement while saving both parties, and society as a whole, a large amount of time, money and human lives.