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Resolving Medical Malpractice Disputes in Massachusetts: Statutory and Judicial Initiatives in Alternative Dispute Resolution

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RESOLVING MEDICAL MALPRACTICE DISPUTES IN MASSACHUSETTS: STATUTORY AND JUDICIAL INITIATIVES IN ALTERNATIVE DISPUTE RESOLUTION

A claim of medical malpractice arises when a person suffers harm as a result of a physician's negligence.[1] In some situations, a deceased patient's survivors may bring a lawsuit against a physician, hospital, or Health Maintenance Organization for failing to diagnose a condition sooner.[2] Such claims may also arise in the context of unsuccessful treatment or where a patient is injured due to a surgical accident.[3] Regardless of whether the harm is physical or psychological, temporary or life-long, visible or invisible, all claims boil down to one factor: whether or not the harm, in the eyes of the law, is considered legally compensable.[4] If the harm does not meet this threshold legal requirement, the plaintiff's day in court is brief.[5] Therefore, a patient may suffer harm at the hands of a medical professional, yet have nowhere to turn if that harm is deemed uncompensable.[6]

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[1] *See* Barbara Hayes Buell, *Taking the Sting Out of Litigation with ADR,* 21 MASS. LAW. WKLY., Sept. 6, 1993, at S3. Buell argues in favor of using alternative dispute resolution methods for resolving medical malpractice disputes. *Id.*

[2] *See* David D. Benjamin, *Mediation: A Better, Faster, Cheaper Way to Resolve Health Care Disputes?,* 25 MASS. LAW. WKLY., May 12, 1997, at B5. Benjamin compares and contrasts the virtues of alternative dispute resolutionwith traditional litigation. *Id.*

[3] *See* Sheila M. Johnson, *A Medical Malpractice Litigator Proposes Mediation,* 52 J. DISP. RESOL. 42, 45 (Spring, 1997). Johnson describes the myriad medical outcomes that lead to medical malpractice lawsuits.

[4] *See id.* at 44. Johnson notes that often times the harm suffered by aggrieved patients does not meet the legal definition of medical negligence.

[5] *See id.* If a medical malpractice plaintiff is unsuccessful in his claim of physician negligence, there are few other avenues of redress. *Id.*

[6] *See id.* The only other option for unsuccessful plantiffs is to lodge a complaint with the state Board of medicine, which does not result in any compensation to the plantiff. *Id.*

Part I of this article will analyze the traditional litigation model for resolving medical malpractice disputes, from both the perspective of patient and provider, as well as the effects on the judicial system.[7] Part II will discuss current statutory and judicial schemes implemented to relieve the burden of upward spiraling caseloads in the Massachusetts court system, including a description of the various methods of dispute resolution now available to litigants.[8] In Part III, the author will argue in support of the use of alternative dispute resolution to resolve medical malpractice disputes as opposed to traditional litigation.[9] This article will conclude with an evaluation of the success of legal reform in Massachusetts and propose further expansion of ADR services in the public justice system.

I. TRADITIONAL LITIGATION

Consider the following hypothetical situation: a patient undergoes needed surgery during which the surgeon accidentally removes a healthy structure. In every other respect, the surgery is a success, but due to the surgical error, the patient must now take medication to compensate for the removal of the healthy structure. The doctor expects the patient to lead a full, healthy life and from the physician's point of view, the patient's health is unaffected. Yet, from the patient's perspective, a harm has resulted that cannot be measured empirically. The physician breached the patient's trust when the physician erred during surgery, and the patient now depends on medication for the rest of his life as a result of that error. Not only will the patient feel angry and betrayed, but he must now struggle to regain his trust in a physician with whom he has a continuing relationship.

Suspending the issue of informed consent and focusing on the harm caused to this potential plaintiff, a claim of medical malpractice would probably fail. This is due to the fact that, while it is true that the physician committed a surgical error, it did not result in any lasting, measurable harm to the patient. Moreover, even if the harm in this case did rise to the level of a legally compensable harm, the next question would be: "How much is it worth?" This raises the

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[7] *See infra* notes 10 through 22 and accompanying text.

[8] *See infra* notes 23 through 97 and accompanying text.

[9] *See infra* notes 98 through 116 and accompanying text.

issue of the difficulty many personal injury plaintiffs face when seeking an attorney to represent them: an attorney would probably be unwilling to take on a lawsuit that will not yield a judgment large enough to cover their costs of litigating the claim, even if liability is clear. In this case, a jury may find that the physician breached her duty of care to the patient, but if the harm seems minimal, the award will result in merely nominal damages. Although the plaintiff had his day in court, he has also paid a high price for it. His attempt to litigate this claim will have cost him considerable time, money and emotional energy. This may be true even if the case eventually settles before trial, for example where such a settlement takes place late in the pre-trial process, when possibly many months of discovery and trial preparation have passed.

The average cost of medical malpractice litigation for both parties ranges from approximately twenty-five thousand to forty-five thousand dollars.[10] As much as a decade may elapse by the time the trial is concluded.[11] In the meantime, both the plaintiff and defendant suffer the psychological consequences of protracted litigation.[12] From the perspective of physician defendants, the lawsuit represents a personal attack on their professional ability and reputation.[13] The

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[10] *See* Thomas B. Metzloff, *Resolving Medical Malpractice Disputes; Imaging the Jury's Shadow*, 54 LAW & CONTEMP. PROBS. 43, 54 & 59 n.55 (Winter, 1991). Because attorneys for both plaintiffs and defendants engage in similar pretrial preparations, it is reasonable to assume relative equality in costs. *See also* Thomas B. Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice,* 9 ALASKA L. REV. 429, 433. Metzloff notes that although the majority of medical malpractice lawsuits are settled before trial, these settlements usually take place "on the courthouse steps," when litigation expenses have already escalated. *Id.*

[11] *See* Buell, *Taking the Sting out of Litigation with ADR, supra* note 1, at S3. Buell discusses the probability of a lengthy process of trial preparation as one of many drawbacks to traditional litigation. *Id.*

[12] *See* Allen K. Hutkin, *Resolving the Medical Malpractice Crisis: Alternatives to Litigation,* 4 J.L. & HEALTH 21, 24 [hereinafter Hutkin, *Resolving the Medical Malpractice Crisis*], in which Hutkin describes the emotional toll of medical malpractice litigation on physicians as a "major life stress". *Id.*

[13] *See* Buell, *Taking the Sting out of Litigation with ADR, supra* note 1, at

time and energy plaintiffs spend litigating a claim often delays the emotional closure needed to move forward with their lives.[14] The financial burden and time delays associated with litigation are felt by the judicial system as well.[15] Limited judicial resources also add to the difficulty of expediting cases through the courts.[16]

Plaintiffs litigating a medical malpractice claim face daunting statistics, exemplified by the fact that the Massachusetts Medical Professional Insurance Association ("MMPIA") receives approximately twelve hundred medical malpractice claims each year.[17] Of those twelve hundred complaints, about eight hundred result in no payment to the complainant.[18] The remainder of the claims are resolved in favor of the physician defendant ninety-three percent of the

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S3. Buell presents the financial and emotional impact on the lives of both parties to the lawsuit, rather than taking a strictly patient-oriented view. *Id.*

[14] *See id.* at S3, wherein Buell opines that "everyone needs closure [and] ... the prompt resolution of a medical malpractice lawsuit."

[15] *See* Honorable Peter W. Agnes, Jr., *A Reform Agenda for Court-Connected Dispute Resolution in Massachusetts,* 40 BOSTON B.J. 4, 5 (Mar./Apr. 1996). Judge Agnes indicated his agreement with public opinion that Massachusetts' courts are overcrowded. *Id.* Judge Agnes went on to identify the two main reasons for this judicial backlog: (1) the complexity of the cases coming before the courts for resolution, and (2) society's reliance on traditional litigation as the only means of resolving such cases. *Id.* at 4.

[16] *See* Mark A. Cohen, *Court Leaders Issue Policy Statement on ADR; Endorse New Dispute Resolution procedures,* 22 MASS. LAW. WKLY., Oct. 11, 1993, at 3. Cohen quoted Supreme Judicial Court Chief Justice Paul J. Liacos, who stated that the Court was committed to serving the needs of all justice consumers despite "budgetary restrictions". *See also* David D. Benjamin, *Mediation: A Better, Faster, Cheaper Way to Resolve Health Care Disputes?, supra* note 2 at B5. Benjamin asserts that the discovery process is inhibited by attorneys who "shop" around for an expert whose opinion will bolster their argument. *Id.*

[17] *See* Buell, *Taking the Sting out of Litigation with ADR, supra* note 1, at S3. Buell notes that the majority of medical malpractice plaintiffs are ultimately unsuccessful. *Id.*

[18] *See id.* These complainants are left only with the option of filing a complaint with the state Board of Medicine. *Id.*

time.[19] With the numbers stacked against the prospective plaintiff, the choice to litigate is a gamble many plaintiffs and their attorneys may be unwilling to take.[20] These statistics account for the relatively low number of medical malpractice claims actually filed.[21] In fact, according to the Harvard Medical Malpractice Study III, less than two percent of all victims of medical malpractice ever sue their doctors.[22]

II. STATUTORY AND JUDICIAL ADR INITIATIVES

In the 1950's, people became more aware of their rights and the 1960's and 1970's witnessed an increase in the number of aggrieved patients seeking redress in the courts.[23] As patients began asserting their rights with increasing frequency, medical malpractice insurance rates soared.[24] As a consequence of increased insurance rates, physi-

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[19] *See id.*

[20] *See* Johnson, *A Medical Malpractice Litigator Proposes Mediation, supra* note 3, at 45. Johnson stresses that tort reform which caps recoverable damages acts as a "disincentive for attorneys to represent patients whose injuries are small or moderate." *Id.*

[21] *See* Hutkin, *Resolving the Medical Malpractice Crisis, supra* note 12, at 25, citing the low number of medical malpractice victims who consult attorneys. Hutkin based his conclusion on a 1987 study in Maine which revealed that only 7% of those surveyed who had suffered harm at the hands of a medical professional actually sought legal advice. *Id.*

[22] *See* A. Russell Localio, J.D., M.P.H., MS., et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence. Results of the Harvard Medical Malpractice Study III,* 325 NEW ENG. J. MED. 245, 245-51 (1991).

[23] *See* Johnson, *A Medical Malpractice Litigator Proposes Mediation, supra* note 3, at 44. Johnson explains that increased awareness of patient rights and growing jury awards created a "medical negligence insurance crisis." *Id. See also* Neil D. Schor, *Health Care Providers and Alternative Dispute Resolution: Needed Medicine to Combat Medical Malpractice Claims,* 4 OHIO ST. J. ON DISP. RESOL. 65, 65 (1988) [hereinafter Schor, *Health Care Providers and ADR*]. Schor comments that this increase in insurance premiums also led to increased costs for health care consumers.

[24] *See* Hutkin, *Resolving the Medical Malpractice Crisis, supra* note 12, at

cians began practicing defensive medicine: the ordering of duplicative or extensive diagnostic services in order to prevent malpractice claims.[25] As health maintenance organizations (HMOs) take the place of independent practices, physicians defending malpractice claims face the added fear of becoming unemployable or losing hospital privileges.[26]

Ultimately, state legislatures recognized the need to contain the ever increasing cost of health care before it grew out of control.[27] The most common response in almost every state was the reform of tort legislation.[28] In 1986, the Massachusetts Legislature imposed caps on the maximum amount of damages recoverable by tort vic-

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22. Between 1974 and 1984, insurance costs increased by 336% and premiums for some specialties doubled in only one year. *Id.*

[25] *See id.* at 25. Hutkin estimates the annual cost of defensive medicine at three to five billion dollars. *Id.* Physicians could not afford to make errors, lest they face costly litigation and increased insurance premiums. *Id.*

[26] *See Data Bank Creates Mixed Emotions,* AM. MED. NEWS, Sept. 7, 1990, at 17. This article focuses on effects of implementation of National Practitioner Data Bank. *Id.* The National Practitioner Data Bank is a product of the Health Quality Improvement Act of 1986. *Id.* Legislators intended to protect the public from medical malpractice by creating a centralized information repository of physicians' performance records. *Id.* The editorial points out that the legislation would require health care facilities to access the Data Bank when considering a physician for employment. *Id. See also* Mark E. Schreiber, *Physicians' Employment Problems and the Practitioner Data Bank,* 23 MASS. LAW. WKLY., Nov. 14, 1994, at 37. Schreiber predicts that employers will use Data Bank information as a "bargaining chip" in negotiations or disputes.

[27] *See* Neil D. Schor, *Health Care Providers and ADR,* 4 OHIO ST. J. ON DISP. RESOL. 65, 65. Schor states that in the 1970's the "health care system [was] headed ... [for] collapse ...*Id. See also* Johnson, *supra* note 3, at 44, where the author points out that a majority of states responded to the crisis with tort reform legislation.

[28] *See* Patricia M. Danzon, *The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims,* 48 OHIO ST. L.J. 413, 413. Danzon's article recognizes that tort legislation was undertaken in "virtually every state." *Id.*

tims.[29] It also provided for the offsetting of verdict awards by collateral source payments.[30] The statute replaced lump sums with structured periodic payments and caps on attorneys' contingency fees.[31] Through tort reform, the legislature hoped to curb the rising cost of liability insurance and health care services as well as provide some relief to the overburdened civil court system.[32] Much debate centered around the efficacy of such legislation, resulting in widespread criticism of tort reform.[33]

In Massachusetts, the debate continues to rage on.[34] Proponents argue that Massachusetts is experiencing a "litigation crisis," spurred on by a "sue or be sued" mentality.[35] As recently as 1995, former Massachusetts Governor William F. Weld proposed broad changes in Massachusetts tort law.[36] The proposal included, but was not limited

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[29] *See* MASS. GEN. LAWS ch. 231, § 60H (1986).

[30] *See id.* The purpose of capping damages was to deter claimants and ease the burden on the court system. *Id.*

[31] *See id.* Offsetting verdict awards by collateral source payments prevents double recovery by successful plaintiffs. *Id.*

[32] *See* Thomas P. Hagen, Note, *"This May Sting a Little"--A Solution to the Medical Malpractice Crisis Requires Insurers, Doctors, Patients, and Lawyers to Take Their Medicine,* 26 SUFFOLK U. L. REV. 147, 154 & 157 (1992) [Hereinafter *"This May Sting a Little"*]. Hagen reviews proposed federal responses to the medical malpractice crisis. *Id.*

[33] *See* Hagen, *This May Sting a Little, supra* note 32, at 159, which describes the disagreement among authorities regarding tort reform's success; *see also* Johnson, *supra* note 3, at 44-45, warning of disincentives caused by award caps for insurance companies to settle and attorneys to accept cases.

[34] *See* Mark A. Cohen, *Bar Steps Forward to Oppose Weld's Tort-Reform Proposal. No Need to Overhaul System, Lawyers Say,* 24 MASS. LAW. WKLY., Mar. 4, 1996, at 1. In this article, Cohen outlines both sides of tort reform dispute. *Id.*

[35] *See id.* Cohen quotes Kathleen M. O'Donnell, then-President of the Massachusetts Association of Trial Attorneys, who stated that, in Massachusetts, a lawsuit is filed every twelve minutes. *Id.*

[36] *See* Claire Papanastasiou Rattigan, *Weld Unveils Sweeping Legal 'Reform' Plan. Plaintiffs' Bar Vows Offensive to Block Bill,* 23 MASS. LAW. WKLY., July 3, 1995, at 1. Weld referred to Massachusetts as "sue happy" and

to, instituting the English rule of losers paying winners' attorneys' fees when settlements were rejected, damage caps, stricter evidentiary standards and sanctions for the filing of "frivolous" lawsuits.[37] Opponents of such legislation, including the Massachusetts Bar Association and the Massachusetts Academy of Trial Attorneys, accused Weld of trying to align himself politically with business interests through the use of such reform, which would favor businesses, including insurance companies.[38] In particular, they criticized the rule requiring the loser to pay the winner's attorneys' fees as increasing the overall costs of litigation.[39] They also characterized damage caps tied to earning capacity as discriminatory and "mean-spirited."[40] Opponents also took issue with Weld's characterization of a "tort crisis" in Massachusetts, stating that his press release erroneously reported that Massachusetts had one of the highest rates of tort filings in the United States.[41]

As early as 1975, the Massachusetts legislature responded to the medical malpractice crisis through the creation of a medical malpractice claims tribunal.[42] Under this enactment, all actions for medical malpractice must appear before the tribunal, comprised of a

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predicted that businesses would suffer without legal reform. *Id.* at 1.

[37] *See id.* The idea was to curtail the escalating number of lawsuits being filed in the Commonwealth by raising the bar for plaintiffs to establish a prima facie case of negligence as well as limiting recoveries. *Id.*

[38] *See id.* Opponents of the proposed legislation felt that Governor Weld was merely attempting to gain political support from the business and insurance sectors while doing little to address the issue of access to the courts for the citizens of the Commonwealth. *Id.*

[39] *See id.* While a "loser pays" rule would certainly help to deter frivolous suits, it would only have the effect of punishing those sincere plaintiffs with valid claims who for any number of reasons did not succeed at trial. *Id.*

[40] *See id.* A verdict should be based on what the factfinder determines to be the extent of the damages suffered by the plaintiff, not their income level. *Id.*

[41] *See* Rattigan, *supra* note 36, at 1. In actuality, the numbers reported in the press release reflected the total number of civil filings per 100,000 citizens in 1992, not merely tort filings. *Id.*

[42] *See* MASS. GEN. LAWS ANN. ch. 231, § 60B (West 1997). The purpose of the tribunal is to screen complaints for meritoriousness. *Id.*

superior court judge, one attorney and one physician.[43] The tribunal, held within fifteen days of the defendant's answer, must determine whether the plaintiff's offer of proof presents a legally cognizable cause of action worthy of adjudication.[44]

In reaching a determination, the tribunal may consider all medical records offered as evidence and, in its discretion, may subpoena any such medical records in order to clarify the evidence presented.[45] If, at the close of the proceeding, the tribunal finds in favor of the defendant(s), the plaintiff is still free to move forward with a lawsuit.[46] The plaintiff must, however, post a six thousand dollar bond with the court clerk, payable to the defendant(s) in the event that the plaintiff loses at trial.[47] Any witnesses called before the tribunal, as well as the tribunal's findings, are admissible as evidence in the subsequent trial.[48]

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[43] *See id.* Both the attorney and physician serving on the tribunal are chosen by the judge and must be licensed to practice in Massachusetts. *Id.* The judge chooses the physician from a list provided by the Massachusetts Medical Society, of physicians practicing in the same field as where alleged malpractice occurred. *Id.* The physicians listed, however, cannot practice in the same county as the defendant, or where the defendant resides. *Id.* Where the claim involves multiple defendants, the judge shall use his or her discretion in choosing the appropriate representative on the tribunal. MASS. GEN. LAWS ANN. ch. 231, § 60 B.

[44] *See id.* This process weeds out those non-meritorious claims which are deemed "merely an unfortunate medical result." *Id.* *See also* Barbara Rabinovitz, *State Statute Explains How Tribunal Processes Cases,* 22 MASS. LAW. WKLY., Nov. 22, 1993, at 43, setting forth the general provisions of the statute.

[45] *See* MASS. GEN. LAWS ANN. ch. 231, § 60B (West 1997). Evidentiary standards are more relaxed than at trial, and the tribunal is given broad discretion in allowing documents "in evidence." *Id.*

[46] *See id.* The finding of the tribunal does not act as an absolute bar to the subsequent filing of a lawsuit. *Id.*

[47] *See id.* The bond serves to protect the defendant(s) from having to pay for a defense in a lawsuit that was deemed unnecessary by the tribunal. *Id.*

[48] *See id.* In this way, plaintiffs are "bound" by the tribunal's findings, because they are admissible and are usually quite persuasive at trial. *Id.*

The value of the tribunal lies in its screening function.[49] This stop-gap measure derails those claims with no legal merit from clogging the already congested docket.[50] A major benefit of early elimination is the avoidance of those costs associated with the discovery process, particularly expert witness fees, which can run very high.[51] Thus, the medical malpractice claims tribunal represents one successful component of the Commonwealth's response to its judicial backlog.

The Massachusetts legislature has acknowledged the importance of early intervention as a means of controlling the flow of cases into the courts.[52] In 1989, the Massachusetts Legislature enacted Massachusetts General Laws chapter 211B § 19, which grants authority to the Chief Justice for Administration and Management to establish a mandatory alternative dispute resolution ("ADR") program for civil actions.[53] Such legislation opens the door for the implementation of other forms of dispute resolution, rather than just the traditional route of litigation.[54]

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[49] *See* Michael J. Lacek, *The Tribunal is Doing Just Fine; Let It Be,* 21 MASS. LAW. WKLY., Feb. 22, 1993, at 11. Lacek defends the utility of the medical malpractice tribunal established by M.G.L. c. 231, § 60B. *Id.*

[50] *Id.* Lacek notes that between the years 1975 and 1992, the tribunals conducted roughly seven thousand hearings and eliminated sixteen percent, or eleven hundred claims. *Id.* Those are cases that, without the tribunal, would have ended up in court. *Id.*

[51] *See* Lacek, *supra* note 49, at 11, stressing that the tribunal's disposition of these claims results in "substantial cost savings."

[52] *See* Barbara E. Stedman, *Middlesex Multi-Door Courthouse,* 24 MASS. LAW. WKLY., June 10, 1996, at B2. Stedman describes the MMDC as a "screening and ... referral mechanism" *Id.*

[53] *See* MASS. GEN. LAWS ANN. ch. 211B § 19. Hence the opportunity for alternative forms of dispute resolution to ease the dockets. *Id.*

[54] *See id.* Disputants' options include case evaluation and management, negotiation, mediation and arbitration. *Id. See also* Barbara Epstein Stedman, *New 'Doors' Open at Middlesex Courthouse,* 23 MASS. LAW. WKLY., July 24, 1995, at B4. This article introduces two more recent "doors" added to the MMDC: the summary jury trial and arbitration/mediation or "arb/med". *Id.*

A prime example of Massachusetts' commitment to improve the quality of justice is the creation of the Middlesex Multi-Door Courthouse ("MMDC") in Cambridge.[55] Established in 1989, the MMDC is a court-annexed evaluation program which diagnoses incoming cases and determines the most appropriate form of dispute resolution.[56] Like the medical malpractice claims tribunal, the MMDC uses a screening process; but unlike the tribunal, it also matches the type of case to the most well-suited resolution mechanism.[57] The MMDC screens approximately fourteen hundred cases each year.[58] Of those cases, roughly five hundred proceed to some form of ADR.[59] An overview of the various ADR mechanisms employed by the MMDC follows.[60]

A. Mediation

In mediation, a neutral third party works with the disputing parties to guide them in designing a settlement that is mutually desirable.[61] Unlike a judge, the mediator does not impose a decision upon the parties, but rather assists them in hammering out their own agreement.[62] The participants may or may not be assisted by counsel and, in some mediations, only the representing attorneys participate

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[55] *See* Stedman, *supra* note 52, at B2. The Multi-Door Courthouse gives potential litigants for alternative forms of dispute resolution. *Id.*

[56] *See* Mark D. Mason, *ADR in Massachusetts: The 90's and Beyond,* 19 MASS. LAW. WKLY., Sept. 9, 1991, at 33. Mason acknowledges that the MMDC has evolved into a successful "coordinated approach to dispute resolution." *Id.*

[57] *See* Stedman, *supra* note 52, at B2. This initial screening process helps to move the case through the system more efficiently. *Id.*

[58] *See* Stedman, *supra* note 52, at B2.

[59] *See id.* This last available figures are from 1996. *Id.*

[60] *See infra* notes 61 through 92 and accompanying text.

[61] *See* American Arbitration Association, *Dispute Resolution Program for Insurance Claims A Procedural Guide,* at 3-4, available in 1991 WL 537127. This procedural guide provides working definitions of mediation and arbitration for those who are unfamiliar with alternative dispute resolution terminology. *Id.*

[62] *See id.* This aspect of "self-determination" increases the likelihood of participants complying with the final agreement. *Id.*

without their clients present.[63] Mediators often caucus individually with the parties in private meetings.[64] Caucuses are extremely useful to the mediator in order to elicit information one party may be unwilling to share with the other party, to foster trust with the mediator, to allow for the diffusion of emotions which can build up during the mediation and to re-focus the parties on the issue.[65] One of the benefits of mediation reported by participants is the opportunity to vent their feelings to the opposing party, whereas traditional litigation discourages parties from talking directly with one another.[66] Participants in the mediation process often report a high level of satisfaction because they have power over the final outcome.[67]

B. Arbitration

Arbitration is an ADR process which may be required under the terms of a contract, or sought after mutual agreement between the parties.[68] Arbitration also involves the use of a neutral third party, but unlike mediation, the arbitrator renders a decision.[69] While the arbitrator assumes a judge-like role by determining a "winner" and

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[63] *See* STEPHEN B. GOLDBERG, ET AL., DISPUTE RESOLUTION 104 (2d ed. 1992). Professor Goldberg explains the mediation process for the uninitiated. *Id.*

[64] *See id.* at 110. Caucuses are extremely useful, especially where an exchange becomes heated between the parties, to defuse the tension. *Id.*

[65] *See supra* note 64 and accompanying text.

[66] *See* Benjamin, *supra* note 2, at B5. Benjamin advocates the use of mediation to resolve health care disputes. *Id.*

[67] *See* GOLDBERG, *supra* note 63, at 148-49. Goldberg postulates that heightened satisfaction with the process results in greater likelihood of compliance with final agreement. *Id.*

[68] *See* Metzloff, *supra* note 10, at 438-39, describing the basics of arbitration; Hutkin, *supra* note 12, at 37. *See also* Patricia I. Carter, *Binding Arbitration in Malpractice Disputes: The Right Prescription for HMO Patients?*, 18 HAMLINE J. PUB. L. & POL'Y, 423, 426 (1997). Carter notes that incorporation of arbitration agreements into contracts has provided HMOs with a cost-effective method of resolving disputes. *Id.*

[69] *See* Hutkin, *supra* note 12, at 37. The parties themselves present their case, but they do not fashion the final agreement. *Id.*

"loser," the decision may or may not be final and binding.[70] Some of the benefits of arbitration include quicker resolution as opposed to litigation, less intimidation compared to the courtroom setting, and relaxed evidentiary standards.[71]

C. *Negotiation*

Sometimes, disputing parties are able to resolve the matter during the initial screening phase.[72] Even where parties voluntarily seek ADR, they are encouraged to try to negotiate among themselves to bring the matter to a close.[73] Settlements are possible at the initial screening phase because it is at this point when the parties hear the reality of their case, realize the strengths and weaknesses of their position, and their chances of prevailing at trial.[74]

D. *Case Evaluation*

Another alternative offered by the MMDC is called "case evaluation."[75] Similar to arbitration, each party presents their case to a neutral third party, usually a judge or attorney.[76] Each party then receives an oral evaluation from the neutral third party regarding the

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[70] *See* Note, *Mandatory Mediation and Summary Jury Trial: Guidelines for Ensuring Fair and Effective Process,* 103 HARV. L. REV. 1086, 1088 (1990) (outlining the basics of the arbitration process).

[71] *See* Stedman, *supra* note 52, at B2. *See also* Schor, *supra* note 27, at 70 (noting some of the advantages of arbitration compared to traditional litigation).

[72] *See id.* At this point, parties get their first realistic look at the odds of succeeding at trial. *Id.*

[73] *See id.* Once parties are exposed to the realities of the strength of their case, they are often more willing to discuss settlement. *Id.*

[74] *See* Hutkin, *supra* note 12, at 38. *See also* Ericka B. Gray , *Case Load Escalates at Middlesex Multi-Door Courthouse,* 20 MASS. LAW. WKLY., June 1, 1992, at 38.

[75] *See* Ericka B. Gray, *Case Load Escalates at Middlesex Multi-Door Courthouse,* 20 MASS. LAW. WKLY., June 1, 1992, at 38.

[76] *See id.* The parties are given a list of possible neutrals from which to choose. *Id.*

merits of the respective cases.[77] The parties may then decide whether to go to trial or select one of the ADR mechanisms.[78] Case evaluation is a valuable tool at the MMDC because it can persuade stubborn parties to pursue other ADR alternatives.[79]

E. Case Management

The MMDC offers another alternative called "case management."[80] Case management is best suited for complex cases, where the discovery process can consume a long period time of time.[81] By providing a structured schedule for the case, the complex case manager helps to keep the case moving, freeing up the court to attend to other more substantive matters.[82] The role of the case manager is usually filled by an attorney or retired judge, who may also play a critical role in facilitating a settlement between the parties.[83]

F. Summary Jury Trial

A more recent addition to the alternatives available at the MMDC, the summary jury trial ("SJT"), is unique in that it involves

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[77] *See id.* This presents another opportunity for the parties to entertain settlement. *Id.*

[78] *See id.* The prospect of waiting many months before a trial may take place is one of the factors that motivates parties to choose alternative dispute resolution. *Id.*

[79] *See id.* Factors such as lengthy pre-trial preparation and costly discovery also serve to motivate parties to choose alternative dispute resolution. *Id.*

[80] *See* Gray, *supra* note 75, at 38. While in this case the parties have chosen to go to trial, case management moves the trial along swiftly and efficiently. *Id.*

[81] *See id.* Complex cases are well-suited to a structured trial schedule due to their tendencey for protracted discovery. *Id.*

[82] *See id.* By setting out a strict schedule of deadlines for completing discovery, pleadings, etc., cases are prevented from stagnating. *Id.*

[83] *See id.* The case manager keeps the parties on track with their deadlines and discourages stalling tactics designed to drag the process out. *Id.*

the use of jurors.[84] The process resembles a trial in fast-forward motion, with each party allowed thirty minutes to present their case to six-person jury.[85] After the jury deliberates and delivers its "verdict," the attorneys for both sides may consult with the jurors to determine what factors influenced their decision.[86] SJT is especially useful in those cases where the disputants are polarized and settlement is unlikely without a "sneak peek" at the possible outcome if they proceed to a trial.[87] Since its inception at the MMDC, the SJT has received favorable feedback from those who have participated in the process.[88]

G. Mediation/Arbitration ("Med-Arb")

This process blends arbitration and mediation in a way that allows both for direct party involvement in the fashioning of a settlement, and at the same time, provides parties with the security of a binding agreement.[89] In this process, the third party neutral formulates a written binding decision which remains undisclosed to the parties during the mediation phase.[90] In the event that the parties

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[84] *See* Barbara Epstein Stedman, *New Doors open at Middlesex Courthouse,* 23 MASS. LAW. WKLY., July 24, 1995, at B4, describing the two newest additions to the MMDC.

[85] *See id.* Stedman notes that in SJT, the voir dire process is foregone. *Id.*

[86] *See id.* Another benefit attributed to the SJT, aside from the use of jurors, is the expedited nature of the proceeding; the entire process, from start to finish, takes about three hours. *Id.*

[87] *See id.* This abbreviated form of trial helps the disputants gain realistic insight into the relative strengths and weaknesses of their case, and how they will platy out at trial. *Id.*

[88] *See* Stedman, *supra* note 84, at B4. After polling those who chose SJT, many participants cited the usefulness of SJT as a means of predetermining the likelihood of success at trial. *Id.*

[89] *See* STEPHEN B. GOLDBERG, ET AL., DISPUTE RESOLUTION 226-228 (2d ed. 1992). The authors note that "a binding resolution is assured in med-arb." *Id.* at 227.

[90] *See id.* at 227. Med-arb is sometimes considered to be superior to "pure" mediation, because it provides for a resolution in the event the parties cannot reach one themselves. *Id.*

reach an impasse and cannot achieve settlement, the written decision of the arbitrator is imposed upon the parties.[91] Med-Arb is best suited to simple, straightforward cases which do not involve complex issues or require a lengthy opinion.[92]

The success of the MMDC prompted the call for a state-wide system of ADR programs in order to facilitate access to ADR for all citizens.[93] In response, the Massachusetts Supreme Judicial Court's Standing Committee on Dispute Resolution issued a policy statement containing its recommendations for court-connected ADR services (most recently amended in the summer of 1996).[94] By advocating the linkage of ADR programs with the courts, the judiciary recognized the value of early intervention as a means of reducing the caseload of the courts.[95] In so doing, it also laid to rest the long-

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[91] *See id.* While this is less preferable than a solution fashioned by the parties themselves, it does provide closure to the situation and prevents a protracted lawsuit. *Id.*

[92] *See id.* at 227-28. The authors are careful to point out that Med-Arb may be a better alternative for those parties that will walk away after the process, as opposed to those parties that will have an ongoing relationship, such as patients and physicians. *Id.* This is due to the possibility of a binding solution being imposed on parties reluctant to accept it, and who may harbor bitterness following such a resolution. *Id.* at 228.

[93] *See* Mason, *supra* note 56, at 33 (arguing for a comprehensive ADR program in order to meet the growing legal needs if the citizenry); *Accessible ADR,* 22 MASS. LAW. WKLY., Feb 14, 1994, at 10 (asserting that the "growth of ad hoc [ADR] programs seems insufficient"). *See also* Honorable Peter W. Agnes, Jr., *ADR and the Future of the Public Justice System,* 21 MASS. LAW. WKLY., Mar. 8, 1993, at S1. Judge Agnes notes that approximately 75% of the cases screened at the MMDC proceed to some form of ADR. *Id.*

[94] *See* Honorable Peter W. Agnes, Jr., *ADR and the Future of the Public Justice System,* 21 MASS. LAW. WKLY., Mar. 8, 1993, at S1; *SJC Committee Releases ADR Recommendations,* 24 MASS. LAW. WKLY., July 1, 1996, at 19. Judge Agnes announced that providing ADR services "[is] essential to the basic mission of the courts." *Id.*

[95] *See SJC Committee Releases ADR Recommendations,* 24 MASS. LAW. WKLY., July 1, 1996, at 19. Through the creation of the Multi-Door Courthouse, disputing parties have "one-stop shopping" for the appropriate forum in which to

standing perception of the judiciary as unwilling to expand the justice system to include other forms of dispute resolution.[96] Both the legislative and judicial endorsement of ADR as an effective means of reducing judicial backlogs as well as costs has paved the way toward greater accessibility to the justice system for all citizens.[97]

III. USING ADR IN THE MEDICAL MALPRACTICE CONTEXT

The nature of the dispute in a medical malpractice case makes it especially amenable to the use of ADR.[98] Furthermore, litigation often fails to meet many of the needs of the parties to such lawsuits.[99] This becomes obvious when one examines the dynamics of the patient-physician relationship.[100] Patients tend to communicate on a

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resolve their dispute. *Id.*

[96] *See* Martin J. Newhouse, *Some Reflections on ADR and the Changing Role of the Courts,* 39 BOSTON B.J. 15, 15 & 18 (1995) Newhouse commends the courts' involvement with and integration of ADR into the public justice system. *Id.*

[97] *See* Martin J. Newhouse, *Some Reflections on ADR and the Changing Role of the Courts, supra* note 96, at 18. Newhouse enthusiatically endorses the courts' expansion into alternative dispute resolution. *Id.*

[98] *See* Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice,* 9 ALASKA L. REV. 429, 433, listing the advantages of using ADR in medical malpractice disputes. *See also* Patricia I. Carter, *Binding Arbitration in malpractice Disputes: The Right Prescription For HMO Patients?,* 18 HAMLINE J.L. & PUB. POL'Y 423, 445. Carter discusses the advantages of using arbitration as opposed to litigation. *Id. See also* Schor, *supra* note 27, at 66, arguing that the use of ADR benefits not only the disputants themselves, but the entire American health care system.

[99] Hutkin, *supra* note 12, at 30-33. Hutkin notes that litigation does not adequately address many of the issues presented in medical malpractice and argues that traditional litigation "only addresses the monetary interests of [litigants]...." *Id.* at 30. *See also* Johnson, *supra* note 3, at 43-44. Johnson cites the Harvard Study, which concluded that less than 2% of medical negligence victims file suit. *Id.* Paul Weiler, a researcher in the Harvard Study, opined that in many cases the compensation received in medical malpractice lawsuits did not appear to correspond to the magnitude of the injury suffered. *Id.* at 44.

[100] *See* Hutkin, *supra* note 12, at 26-28. The author explains that patients

more emotional level, especially when they are ill; doctors, however, are encouraged to avoid this level of communication as a means of remaining professionally detached.[101] This miscommunication can lead to misunderstandings that, in turn, can cause conflicts to arise.[102] When patients do not understand their medical condition or why certain consequences followed from a particular course of treatment, the potential exists for anger, resentment, and distrust to develop.[103] Yet, patients often keep these feelings to themselves because they are either too angry or intimidated to confront their physicians.[104] This demonstrates the intimate nature of the patient-physician relationship. As it is often said: "effective communication is at the core of every good relationship"--the patient-physician relationship is no exception to this rule.[105]

Given that communication is often at the heart of these disputes, it is obvious why traditional litigation fails to satisfy the needs of the parties.[106] Someone who feels that they have suffered harm due to a physician's or hospital's negligence may be seeking more than just money, yet traditional litigation can offer nothing more to those victims.[107] On the other hand, ADR has proved extremely effective in

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often have unrealistic expectations about their physician's ability to treat and cure. *Id.*

[101] *See id.* at 27 (stating that physicians use the "broken machine model" to filter out irrelevant information coming from the patient and focus on the symptoms).

[102] *See id.* at 28-29 (referring to this situation as a "clash of perspectives").

[103] *See id.* at 29. Hutkin notes that physicians may think they should spare their patients complex and often confusing information, whereas patients often feel "disregarded, ignored, and patronized" when their doctors do not fully disclose information. *Id.*

[104] Hutkin, *supra* note 12, at 29-30. Hutkin states that "As the physician-patient relationship falters, the attorney-client relationship strengthens." *Id.*

[105] *See* Johnson, *supra* note 3, at 49. Johnson discusses the importance of maintaining a relationship with one's physician, especially in light of the burgeoning institutionalization of health care. *Id.*

[106] *See id.* at 30 (stressing that money often inadequately compensates plaintiffs for their harm).

[107] *See id.* (commenting that plaintiffs seek "reparation, emotional

this respect.[108] For example, by using a mediator to facilitate settlement, both parties have the opportunity to express themselves directly to one another.[109] The presence of the mediator serves to "level the playing field," which decreases the anxiety and intimidation patients might ordinarily feel when discussing their discontent with the physician.[110]

Mediation is by far the most popular form of ADR for resolving medical malpractice claims.[111] The mediator helps the parties to understand each other's point of view, allowing for the diffusion of emotions, which helps them focus on possible solutions.[112] The ability to shape their solution provides flexibility and encourages creativity in satisfying the interests of both parties.[113] Another benefit of mediation is the opportunity for one or both parties to apologize.[114]

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vindication, and deterrence"). *See also* Benjamin, *supra* note 2, at B5. Benjamin asserts that a money award often fails to adequately compensate med-mal plaintiffs. *Id.*

[108] *See* Johnson, *supra* note 3, at 49 (proposing mediation for resolving medical malpractice disputes). Johnson asserts that mediation allows the parties to discuss the underlying issues of the dispute, which may or may not be related to liability. *Id.* In this way, Johnson argues, both patients and physicians have the opportunity to vent their feelings. *Id. See also* Benjamin, *supra* note 2, at B5. Benjamin points out that settlement agreements formulated through mediation address many of the issues in which the dispute is grounded. *Id.*

[109] *See* Leonard J. Marcus, *Case Study Shows Mediation in a Licensure Dispute,* 39 AM. MED. NEWS, Aug. 5, 1996, at 11. This article illustrates a mediation in action.

[110] *See id.* Marcus points to the lack of relative power on the patient's end of the patient-physician relationship as one of the reasons that communication often breaks down between a patient and physician, leading to litigation. *Id.*

[111] Buell, *supra* note 1, at B5. Buell cites the overwhelming majority of participants in mediation who report satisfaction with the outcome. *Id.*

[112] *See id.* Buell notes that the presence of a third party neutral helps to keep the parties on track and focused on solutions, rather than rehashing their differences. *Id.*

[113] *See id.* Buell lists some common elements of settlement agreements, such as apologies, charitable donations, and continuing education. *Id.*

[114] *See id.* Buell implies that the power of apology to resolve many disputes

The power of apology is frequently overlooked and discouraged in traditional litigation, where it is construed as an admission of liability.[115] Yet, this simple gesture has a profound impact upon a plaintiff and often goes a long way toward reaching a settlement.[116]

IV. CONCLUSION

This brief discussion of mediation illustrates the value of alternatives to medical malpractice litigation. In addition to the benefits and flexibility afforded by the use of ADR in this context, it also presents a viable alternative for those unable to afford traditional litigation. ADR serves to provide an opportunity to be heard for those whose complaints might otherwise be deemed to lack legal merit. As a result, both patients and health care providers will benefit because the time, expense and emotional energy consumed by the trial process will be saved. Furthermore, the patient-physician relationship will benefit from the existence of alternatives to litigation. Patients will feel more comfortable and confident knowing that an appropriate forum exists in which to air their complaints. Health care providers will feel less threatened by the prospect of litigation and, as a result, will not feel compelled to practice medicine defensively. This is especially true where ADR is provided for in the terms of the contract between patient and provider. Attorneys also benefit form the use of ADR because they will have more options to offer their clients. Thus, they will better serve both their clients and the community at large, which will strengthen the community's confidence in the justice system overall and reflect favorably upon the legal profession.

Through the implementation of the Medical Malpractice Claims Tribunal and the ever-expanding Multi-Door Courthouse, Massachusetts continues to fulfill its commitment to providing a more com-

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is under-recognized. *Id.*

[115] *See* ROGER FISHER & WILLIAM URY, GETTING TO YES, 32 (2d ed. 1991). Fisher and Ury provide a practical guide for improving one's communicative and negotiating skills to facilitate settlement of disputes. *Id.*

[116] *See id.* Again, the authors here recognize the importance of simple courteous gestures as a means of perhaps not fully resolving a dispute, but helping to soothe egos and civilize the resolution process. *Id.*

plete package of justice services to its citizenry. The appropriateness of ADR in the medical malpractice context further serves to alleviate the distrust and acrimony often expressed by medical professionals toward the legal profession. Finally, the ultimate beneficiary is every health care consumer, who now has greater access to the judicial system; a system better equipped to meet their needs.

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