MEDIATION AND MEDICAL MALPRACTICE: PROBLEMS WITH DEFINITION AND IMPLEMENTATION

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I

INTRODUCTION

An important aspect of the perceived problem with medical malpractice litigation is the manner in which malpractice claims are resolved.[1] Following the first medical malpractice crisis in the mid-1970s and the more recent difficulties with insurance costs and availability, the majority of states enacted legislation affecting the procedures used to resolve malpractice claims.[2] Procedural reforms have been motivated by a variety of concerns, including: (1) perceptions of an increasing number of medical malpractice claims filed; (2) fear that a large number of small claims are never filed because of the high transaction costs associated with litigation; (3) the unpredictability of litigated outcomes; (4) the perceived inconsistency of jury damage awards; and (5) the potential impact of the litigation system on the availability of malpractice insurance and the delivery of medical care. The procedural changes vary considerably. Some reforms were intended to have substantive effects;[3] other

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* Assistant Dean, Office of International Studies and Programs, University of Wisconsin-Madison. The research described in this article was supported by grants from the State Justice Institute and the Disputes Processing Research Program ("DPRP") of the Institute for Legal Studies, University of Wisconsin Law School. Their support is gratefully acknowledged. The opinions expressed in this article are those of the author and do not represent the official position or policies of the State Justice Institute or DPRP. Earlier versions of this piece were presented at panel sessions of the Law and Society Association annual meetings in 1989 (Madison) and 1990 (Berkeley).

I extend my appreciation to the many people who have helped me in the course of my research: Mr. Randy Sproule and the entire staff of the Medical Mediation Panel System office for their assistance and cooperation with this study; Howard Bellman, John Esser, Marc Galanter, Chris Honeyman, John Lande, Marlynn May, Deb Nudelman, Louise Trubek, and David Trubek for comments on earlier drafts; Thomas Metzloff and Jeffrey Rice of Duke University School of Law for editorial assistance with this article; and most importantly Kathleen Miezio, without whose able assistance these last two years, this research would not have been possible.

1. Glen O. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 L & Contemp Probs 5 (Spring 1986); Robert Ackerman, *Medical Malpractice: A Time for More Talk and Less Rhetoric*, 37 Mercer L Rev 725 (1986).

2. Frank A. Sloan, Paula Mergenhagen & Randall R. Bovbjerg, *Effects of Tort Reform on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 J Health Pol, Pol'y & L 663 (1989); Shirley Qual, *A Survey of Medical Malpractice Tort Reform*, 12 W Mitchell L Rev 417 (1986); US Gen Acct'g Office, *Medical Malpractice—No Agreement on the Problems or Solutions* 83 (1986) (GAO/HRD-86-50).

3. Many states have legislative enactments that shorten the statute of limitations period for malpractice claims, thereby precluding the pursuit of otherwise valid claims. For a general

changes can be characterized as procedural "fine tuning" to correct perceived problems with present procedural rules.[4] Whatever the motivation, attempts to alter the way medical malpractice claims are processed have been an integral part of legislative tort reform.

An important aspect of the procedural reform agenda is a general interest in developing new mechanisms that serve, directly or indirectly, to channel malpractice claims away from the courts. These more innovative changes adopt many of the procedural forms and goals of what is now termed "alternative dispute resolution" ("ADR"). One motivation for developing alternative forums for claims processing is the commonly held belief that the traditional litigation system is inefficient and inequitable,[5] that is, that it fails to provide prompt redress to those injured as a result of medical negligence. Legislation has sought specifically to speed the processing and resolution of claims, to reduce costs to parties and state court systems, and to improve the quality of decisionmaking in malpractice cases.[6] A central purpose of any alternative process is the settlement of claims before trial.

The most common alternative procedures have been arbitration and the required submission of malpractice claims to pretrial screening panels. Despite repeated claims about arbitration's potential benefits, apparently few health care claimants have chosen to agree to binding arbitration, and thus little information is available regarding its impact.[7] Pretrial screening panels,

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discussion of the various measures adopted by several states, see Robinson, 49 L & Contemp Probs at 21 (cited in note 1).

4. For example, some states have imposed special pleading requirements, restructured the discovery process, or limited those able to serve as experts. *Id* at 21-24; see generally Walter Gellhorn, *Medical Malpractice Litigation (U.S.)—Medical Mishap Compensation (N.Z.)*, 73 Cornell L Rev 170, 170-77 (1987-88). Yet another approach is to require a certificate of merit, an expert panel review, or an affidavit from a medical expert certifying the merit of the claim to ensure review before claims are filed. Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims* 45 (RAND, 1982); William Curran, *Screening Panels in Malpractice Cases: Some Disturbing Progress Reports*, 302 New Eng J Med 954 (1980).

5. Inefficiencies arise in part through excessive transaction costs, which have been estimated to be as high as 70%. Jeffrey O'Connell, *An Alternative to Abandoning Tort Liability: Elective No-fault Insurance for Many Kinds of Injuries*, 60 Minn L Rev 501, 503-10 (1976). See also James S. Kakalik & Nicholas M. Pace, *Costs and Compensation Paid in Tort Litigation* 55 (RAND, 1986). See generally Am Med Ass'n, *A Proposed Alternative To The Civil Justice System For Resolving Medical Liability Disputes: A Fault-Based, Administrative System* (Am Med Ass'n, 1988) (Specialty Society Medical Liability Project Report).

6. Legislative reform often encompasses numerous conflicting goals. Cause and effect relations among the many variables affecting claims processing are not well understood, and legislation rarely articulates program goals clearly. Furthermore, program evaluations and assessments rarely examine the impact of new institutional arrangements on the people who use them. Nevertheless, the potential of diversion programs to achieve all or some of these goals has been a major factor in recent state experiments with ADR.

7. Consumers seem reticent to give up their rights to court hearings; others have challenged the constitutionality of arbitration proceedings. Critics argue that arbitration agreements are unenforceable contracts and that binding arbitration in the medical malpractice area will lead to stasis in health care. Nicholas Terry, *The Technical and Conceptual Flaws of Medical Malpractice Arbitration*, 30 St Louis U L Rev 571, 630-31 (1986). Patricia Danzon has written that arbitration statutes appear to result in increased claim frequency but reduced overall average magnitude of claims. She adds that additional information is needed to prove that arbitration schemes have a systematic effect on medical malpractice claims. Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 L & Contemp Probs 57, 77-78 (Spring 1986).

in various forms, operate in approximately half the states; their purpose is to review malpractice claims early in the litigation process to identify and discourage meritless claims, as well as to identify meritorious claims that might be settled early.[8] As with arbitration, there is little empirical evidence about the efficacy of these procedures.[9]

There is a growing interest among state court administrators, practitioner groups, and health care professionals in exploring other alternative means of processing and settling malpractice claims. This interest may result in part from frustration with the arbitration and pretrial screening schemes just described, and in part from tales of successful innovative ADR techniques used in other contexts. Recently, reform discussions have focused on mediation. In mediation, parties participate directly in what is thought to be an informal and voluntary dispute resolution process that may offer a novel and promising approach to resolving claims.

General interest in mediation has been manifested in a number of statutory reforms labelled "mediation" that apply directly or indirectly to malpractice claims. Recent statutory provisions adopting such schemes emerge in part from state legislative confrontations over two major and separable social and legal phenomena: first, recurring calls for innovative and effective processing of medical malpractice claims, and, second, legislative initiatives mandating alternative dispute resolution processes for all or selected disputes. To date, we know little about how these legislative schemes operate and what has been accomplished. Opinion on the likelihood of program success is mixed; what to some seems the perfect match of case type and process appears to others incongruous, a waste of time, or dangerous.

This article begins with an overview of traditional mediation and an examination of the theoretical benefits of mediation as a procedural response to the problems of resolving medical malpractice claims. The article then explores Wisconsin's recent efforts to resolve medical malpractice claims by requiring their mediation. After describing the statute enacting the procedure and the methodology used to study the system, the article evaluates the statute's impact on settlements and describes the mediation process at work. The data derive from statistical reports of the Wisconsin panel system as well as observations and interviews from an ongoing empirical study.

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8. Panels typically consist of lawyers, physicians, retired judges, and insurers. They render decisions on liability and sometimes on damages, but those decisions are not usually binding unless both parties agree. Either party may take an unsuccessful claim at this level to the appropriate state court, but sanctions may be imposed on those who do no better in court than they would have under a panel decision.

9. Panel procedures typically require significant investments of time and money in preparing for the hearing. Pretrial screening panels have been criticized as a costly additional hurdle. Martin Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Challenges*, 55 Tex L Rev 759, 765 (1977); James A. Henderson, Jr., *Agreements Changing the Forum for Resolving Malpractice Claims*, 49 L & Contemp Probs 243, 249-50 (Spring 1986). Nevertheless, recent commentators continue to urge their adoption. Neil Schor, *Health Care Providers and Alternative Dispute Resolution: Needed Medicine to Combat Medical Malpractice Claims*, 4 Ohio St J on Disp Resolution 65 (1988).

The article then analyzes the apparent failure of the Wisconsin system to settle claims and the general implications of this failure for the viability of mediation in the malpractice context. The perceived failure of Wisconsin's approach is not necessarily an indictment of the prospects for mediation in medical malpractice cases, because the label "mediation" only roughly corresponds to the actual structure and operation of Wisconsin's process. The article concludes by focusing on possible features of a more viable mediation program.

II

THE THEORETICAL BENEFITS OF MEDIATION AS A PROCEDURAL APPROACH TO RESOLVING MEDICAL MALPRACTICE CLAIMS

As traditionally understood, mediation is a voluntary, nonbinding process in which a neutral party—the mediator—works with disputants toward resolving or mitigating their conflict in a mutually satisfactory settlement. Mediation attempts to remove the parties' adversarial posturing and replace it with a harmonious relationship. This transformation may take place by an explicit agreement, a reciprocal acceptance of the "social norms" relevant to the parties' relationship, or by a mutual recognition of a new or more perceptive understanding of one another's problems.[10] The variables that shape mediation are so numerous that it is more helpful to view mediation not as a specific model but rather as a style or approach to dispute resolution.[11] The exact format of the mediation session will depend upon the mediators, their experience, the parties, and the type of dispute involved.

Mediation is thought to provide opportunities for both parties to benefit from the resolution of the dispute. For this reason, it is often referred to as a "win/win" process. It offers this advantage because it is not bound by the rules of either procedural or substantive law, by the rules of evidence, or by certain assumptions that dominate the adversary process. The parties "may, with the help of their mediator, consider a comprehensive mix of their needs, interests, and whatever else they deem relevant" to the dispute.[12] The ultimate authority in mediation belongs to the participants themselves, and they may fashion a unique solution without being either strictly governed by precedent or unduly concerned with the precedent they may set for others. Through a process of integrative bargaining, the parties can often reach a mutually satisfactory solution.[13] Unlike the adjudicative process, mediation need not emphasize who is right or wrong, or who wins or loses. Rather, mediation allows parties to strive for a workable solution that meets both

10. Lon Fuller, *Mediation—Its Forms and Functions*, 44 S Cal L Rev 305, 308 (1971).

11. Jay Folberg & Alison Taylor, *Mediation* 130 (Jossey-Bass, 1984).

12. *Id* at 10.

13. See generally Roger Fisher & William Ury, *Getting to Yes* (Houghton Mifflin, 1981).

parties' particular needs and interests.[14] Equally important to some are mediation's goals of reconciliation and personal transformation.[15]

The mediator's role can vary significantly depending on the nature of the dispute. One issue for the mediator is to determine whether to focus on the parties' immediate or long-term needs. Mediators typically are also involved in probing the disputants' subjective understanding of the dispute. The mediator then assists the parties in developing solutions to the conflict, applying neutral standards to these needs and beliefs as a means of developing the middle ground upon which the parties can agree and settle their dispute. By definition, the mediator does not have the formal authority to render a decision in the case. The mediator generally does not even give an advisory opinion on the merits of the dispute, unless requested to do so by the parties, and then typically only after the parties fail to reach an accord voluntarily.

Mediation is often believed to work best in a dispute in which the parties have had a significant prior relationship or when the parties have an interest in continuing a relationship in the future.[16] For this reason, mediation has been widely employed in disputes between family members, neighbors, and landlords and tenants. Indeed, an increasing number of states have passed legislation requiring mandatory mediation in specific dispute contexts, including farmer-lender and agricultural property cases,[17] and family law matters such as divorce and child custody cases.[18] Several states also have enacted sweeping legislation authorizing or mandating mediation generally in civil cases.[19]

Mandatory mediation's recent allure stems from hopes that it will serve as a costless precondition to more formal litigation, and reflects a growing belief that some disputes are better resolved through a consensual process. The type of mediation described above can be thought about as an ideal type—an optimistic rendering of a process that in its voluntary and now mandatory

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14. Folberg & Taylor, *Mediation* at 10 (cited in note 11).

15. Robert Baruch Bush, *Defining Quality in Dispute Resolution: Taxonomies and Anti-Taxonomies of Quality Arguments*, 66 Denver U L Rev 335 (1989). Bush asserts generally that few commentators, dispute scholars, or court administrators have paid any attention to the alternative vision of mediation as a way to expand personal and individual understanding and to transform participants as part of a process of moral education. Emphasizing mediation as a tool of efficiency and an adjunct to the individual-rights focused court system does not allow for personal growth and transformation; the latter process relies on finding value in being connected to and serving others. Robert Baruch Bush, *Mediation and Adjudication, Dispute Resolution and Ideology: An Imaginary Conversation*, 3 J Contemp Legal Issues 1 (1989).

16. John S. Murray, Alan Scott Rau & Edward F. Sherman, *Process of Dispute Resolution: The Role of Lawyers* 287 (Foundation Press, 1989).

17. Nat'l Inst Disp Resolution, *Farmer-Lender Mediation*, Forum (Fall 1990).

18. Patricia Winks, *Divorce Mediation: A Non-adversary Procedure for the No-fault Divorce*, 19 J Fam L 615 (1980-81); Lenard Marlow, *The Rule of Law in Divorce Mediation*, 9 Mediation Q 5 (1985); see generally Comment, *Mediation: New Process for High School Disciplinary Expulsions*, 84 Nw U L Rev 736 (1990) (authored by James McMasters).

19. Fla Stat § 44.302 (West, 1988); Texas Civil Prac & Rem Code Ann § 154 (Vernon, Supp 1989); Okla Stat Ann App R 7(d) (West, Supp 1990); Minn Stat Ann § 484.74 (West, Supp 1990). To date, most have survived constitutional challenge. See Dwight Golann, *Making Alternative Dispute Resolution Mandatory: The Constitutional Issues*, 68 Or L Rev 487 (1989).

versions actually takes numerous forms. Not everyone feels that mandatory mediation is a panacea or an unmixed blessing to litigants; nor have all of the claims for mandatory mediation been proven decisively.[20] Indeed, there is a growing debate over the use of mediation techniques and whether it is appropriate to require mediation in conjunction with existing litigation.[21] Thoughtful commentators consider both the strengths and potential weaknesses of mandatory schemes invoking mediation, and the need to build in protections for fairness, accountability, and quality of the mediation services rendered. Others note that mediation may be quite different in a mandatory context than in a voluntary one, when the judicial administrative motive for its invocation is the goal of reducing court congestion, and urge careful contextualized study of mediation in different settings.[22]

Despite these concerns, mediation has found significant support in public and governmental circles; thus it is not surprising that in recent years a number of states have enacted programs ostensibly purporting to encourage or require "mediation" as an alternative forum for resolving medical malpractice claims.[23] Some states have optional mediation of medical malpractice claims, while many more have general mediation programs that cover medical malpractice cases as well.[24]

The basic theory of mediation, with its emphasis on reconciliation and integrative bargaining, might, in the first instance, seem an unlikely approach to resolving most medical malpractice cases. For example, in the typical case involving birth-related injuries of a newborn child, the main issue is generally a question of whether or not the physician adhered to the applicable standard of care. The claimed damages in such a case could easily total millions of dollars. Often there would not be a long-standing relationship between the doctor and patient and probably no future relationship is anticipated. Given the parties' relationship and the issues, there would seem to be no room for mediation and its conciliatory process.

It is at least possible, however, that some medical malpractice cases would benefit from the use of mediation. Increasing evidence suggests that parties want something in addition to a monetary payment. Plaintiffs may want to know why something happened. They want to be heard and have an opportunity to express their anxieties over what has happened, and at times they want an apology. Occasionally, they just want to know "it will never

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20. See Lawrence Mann, *Mediation of Civil Cases: Neither Panacea Nor Anathema (A Prescription for Change in Procedural Rules)*, 67 U Detroit L Rev 531 (1990).

21. See, for example, Thomas Brady, ed, *Dispute Resolution and the Courts: A Report on the National Conference on Dispute Resolution and the Courts* (Nat'l Inst Disp Resolution, State Justice Institute, and NCSC Publication, 1989); Linda Singer, *The Quiet Revolution in Dispute Settlement*, 7 Mediation Q 105 (1989).

22. Steven Lubet, *Some Early Observations on an Experiment with Mandatory Mediation*, 1989 J Disp Resolution 235; Thomas Fee, ed, *What We Know—And Don't Know—About Mediation*, Disp Resolution Forum 9-13 (October 1989); Bruce Tallcott, *Court-Ordered Mediation in Florida*, 23 Mediation Q 77 (1989).

23. See, for example, Mich Comp L § 600.4903 (1990).

24. Texas Civil Prac & Rem Code Ann § 154.

happen again."[25] Mediation, by providing a means for doctors to explain why something was done the way it was, conceivably offers an inexpensive method of resolving such claims without litigation. For these reasons, certain medical malpractice cases may benefit from mediation.

One of the most focused and comprehensive efforts to utilize mediation techniques in the malpractice context has occurred in Wisconsin. As detailed in the next section, Wisconsin replaced its malpractice screening panel procedure with a new comprehensive regime, ostensibly described as mediation, and required its use. A careful review of Wisconsin's approach should therefore provide important insights into mediation's potential utility in resolving malpractice disputes.

III

MANDATORY MEDIATION OF MEDICAL MALPRACTICE CLAIMS: THE WISCONSIN EXPERIENCE

A. Panel Structure and Procedures

As other states moved towards voluntary arbitration or certificates of merit, or retained ongoing versions of fact-finding prescreening panels, Wisconsin took a different path. In a special legislative session in May 1986, the Wisconsin legislature enacted Act 340 requiring prelitigation mediation for all medical malpractice claims.[26] As a product of intense lobbying and political activity within the state from 1985 to 1986, the legislation replaced a mandatory pre-screening panel system—the Patient Compensation Panels ("PCPs")—in operation since 1975 with the new mandatory mediation panel system ("MMPS").[27]

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25. See Ann Kellett, *Healing Angry Wounds: The Role of Apology and Mediation in Disputes Between Physicians and Patients*, 1987 J Disp Resolution 111; Karl Slaikeu, *Designing Dispute Resolution Systems in the Health Care Industry*, 5 Negotiation J 395 (1989); Marlynn May & Daniel B. Stengel, *Who Sues Their Doctors? How Patients Handle Medical Grievances*, 24 L & Soc'y Rev 105 (1990); Comment, *Mediation and Medical Malpractice Disputes: Potential Obstacles in the Traditional Lawyer's Perspective*, 1990 J Disp Resolution 371.

26. Wis Stat § 655-6.

27. The PCPs took one of two forms (a formal five-member panel or an informal three-member panel) and determined negligence and causation, and awarded compensation. The constitutionality of the panels was upheld in 1978. See *State ex rel Strykowski v Wilkie*, 81 Wis 2d 491, 261 NW2d 434 (1978). Wisconsin State Medical Society figures for 1980-84 suggest that the number of paid claims increased 142% and average payments increased 65% in that period. The Office of the Director of State Courts nevertheless reported that the PCPs successfully screened out one-third of claims coming to them either by voluntary or involuntary dismissal, and settled another one-third of those that came to panels. See Office of the Director for State Courts, *Status Report on the Medical Mediation Panel System in Wisconsin* (1987-89) (covering September 1, 1986, to December 31, 1988, in three reports) ("*Status Report*"); Molly Plunkett, *The Patient Compensation Panels System: A Review of the Evidence* 1986 (unpub essay, U Wis Law School) (on file with author). The popular press reported at that time that panels resolved 90% of the claims but were not reducing the costs associated with medical malpractice litigation. Milwaukee Journal 1B, 2B (September 24, 1987). Diverse criticisms assailed PCPs: they were seen to be inefficient, biased in favor of physicians or the plaintiffs' bar (depending on who was speaking), and unable to reduce perceived high costs of litigation or lower the number of cases going on to jury trial. These criticisms intensified during the 1985-86 legislative session, and a political compromise bill led to the enactment of Act 340.

Under the new statute, claimants are required to file a request for mediation within fifteen days of filing their malpractice claim. A claimant may also request mediation before filing. (This study identifies these claims as "prefiling" claims.) The statute of limitations for all causes of action is tolled for the ninety-day mediation period and an additional thirty days following the end of the mediation period. Parties must submit a statement of the claim or rebuttal to a claim, and share all patient health care records in their possession. Conducting discovery, such as depositions of witnesses and additional compulsory production of records, is specifically prohibited during the mediation period.

The Office of the Director of State Courts administers the panel program. The enacting statute provided little detail on how the mediation system was to be run; thus the administrative office developed its own set of guiding principles and practices in the fall of 1986. Statutory guidelines[28] require panels to consist of three members: an attorney who chairs the panel, a physician or health professional with some expertise in the area of the claim, and a public member appointed from a pool of names provided by the governor. The panel members receive very little training: the attorney-members receive three hours of instruction from a private mediator skilled in mediation training, but the other panel members typically receive no mediation training.

In operation, panel composition remains very similar to that of the PCPs. At the invitation of the administrative office, most of the attorney-chairs of the old panels continue to serve as chairs of the new mediation panels. Many physicians now serving on the mediation panels served before as well.[29] Turnover occurs most frequently with the public member. Every two years, the sitting governor changes all public appointments to state advisory committees, boards, and other state service institutions. As part of this reappointment, the statewide pool of approximately 200 people available for mediation panels can change considerably. Each panel member assumes an assigned role: the attorney assumes the role of the legal expert and mediating chair, the physician that of the neutral medical expert, and the lay member that of the "juror."[30]

Panels are to meet within the ninety-day mediation period. If a meeting cannot be arranged, mediation proceeds only if both parties stipulate to an extension. In practice, it appears that the mandatory nature of the process is unenforceable. Many attorneys are by-passing mediation by various means. In some claims, parties cannot meet within the ninety-day period and one party does not agree to continue the mediation process. Conceivably, delay and last-minute cancellations are purposeful in order to avoid mediation.

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28. Wis Stat § 655.465(2).

29. Until 1986, physicians were required to serve on at least one PCP if asked by the state. Under the MMPS, there is no compulsory service requirement; physicians who serve as MMPS members do so voluntarily.

30. All members receive $150 per panel attended as well as minor reimbursements for travel and meals.

Recent Wisconsin judicial decisions have held that failing to mediate within the ninety-day period does not vitiate a claimant's right to pursue the claim in court.[31] Some high-value claims can by-pass mediation altogether if the MMPS office—in the exercise of administrative discretion[32]—determines mediation is unlikely to promote settlement or assist the negotiation process. The project data base indicates that 15 percent of the claims are excused from mediation by MMPS each year.

Parties must attend the mediation session unless excused by the MMPS office. Panel sessions are informal and nonbinding; no records are kept, and nothing said in a session is admissible in a subsequent court action. In theory, panels do not render decisions. They are to facilitate compromise and settlement where possible, but if mediation does not produce agreement, panel members are then free to advise parties on their projections of the likely outcome should the case proceed to trial.[33]

B. Research Methodology

The Wisconsin program requires examination in an innovative manner. This study attempts a contextual evaluation of the MMPS by locating the panels within a "social field"[34] influenced by many factors, including the incidence and nature of medical malpractice occurrences, health care delivery systems, doctor-patient relations, consumer interests, and the economics of health care and medical insurance. The study also locates the panels within

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31. In *Gauger v Mueller*, 149 Wis 2d 737, 439 NW2d 637 (Wis Ct App 1989), the court held that the statutory language establishing the ninety-day period for conducting mediation was a directive (to the courts) rather than a mandate. Therefore the plaintiffs' failure to mediate within the statutory period did not preclude the trial court from exercising jurisdiction over the claim or allowing an untimely mediation. See *Schulz v Nienhuis*, 152 Wis 2d 434, 448 NW2d 655 (1989); *Scheunemann v Rowe*, 156 Wis 2d 302, 456 NW2d 302 (1990); *Eby v Kozarek*, 153 Wis 2d 75, 450 NW2d 249 (1990).

32. There is no provision in the statute for by-passing mediation; thus one could argue that the MMPS office is inappropriately allowing some cases to avoid mediation. However the legislation provides that the state intended the process to provide an "informal, inexpensive and expedient means for resolving disputes without litigation and intends that the director administer the mediation system accordingly." Wis Stat § 655.42 (1). This language arguably allows the director the latitude he has exercised in administering the program.

33. Standard descriptions of the typical session mention that parties, through their attorneys, present a brief oral statement of their case, followed by ex parte meetings with the panel. The mediators are supposed to

> discuss the strengths and weaknesses of the case, discuss their recommended disposition or settlement figure and ascertain the "bottom line" settlement positions of the parties. The mediators continue shuttling back and forth between the parties for the ex parte discussions until the matter is resolved or until the parties reach an impasse, at which time the session is concluded *and the mediators provide the parties with their objective evaluation of the case.*

Office of the State Courts, *Status Report on the Medical Mediation Panel System in Wisconsin* 3-4 (1989) (report for 1988) ("*1988 Status Report*").

It is interesting to note that the formal description of the process as described by the administering office in its reports to the legislature changed between 1988 and 1989. For example, the italicized portions of the above paragraph did not appear in the earlier report.

34. The terms "social field" and "legal field" are adaptations of Pierre Bordieu's notion of the "juridical field." See Pierre Bordieu, *The Force of Law: Toward A Sociology of the Legal Field*, 38 Hastings L J 805 (1987). The terms are used here to denote areas of structured, socially defined activity or practices that affect individual and group behavior, and their impact on the creation, generation, and revision of social and legal institutions.

an equally complex "legal field"[35] of personal injury litigation within which lawyers, judges, and ADR advocates compete and interact, motivated by disparate concerns for, respectively, aggressive advocacy of clients' interests, efficient docket management, and economical negotiation and settlement of disputes. The study uses methods of inquiry that emphasize and assess the unique features of the MMPS and provide a way for interested system participants and observers to contribute to the assessment process.[36]

The project conceptualizes the MMPS as an intervention into, and additional component of, the normal bargaining and settlement structures operating within the state court system. The field of dispute resolution can be seen as a collection of legal strategies and remedies. Negotiation and bargaining between parties occurs continually during the disputing process—from the time a claim is voiced, blame is asserted, and redress is demanded, through the period of formal litigation.[37]

The MMPS has the potential to affect a particular segment of claims within what might be called the "bargaining/settlement pyramid."[38] Specifically, one of its purposes is to emphasize the processing and settlement of small claims that might not otherwise be able to proceed because of the high transaction costs of litigation, and meritless claims, which the state and respondent wish to remove from the courts as soon as possible. MMPS is seen as freezing the pretrial portion of the bargaining pyramid for one last effort at negotiation and settlement while transaction costs remain low. One purpose of this study is to determine whether mediation at this stage is effective in achieving these two stated MMPS goals.

Various data-gathering techniques have been used to accumulate information on the MMPS. First, the project constructed a data base for a universe of 870 claims filed and mediated between September 1, 1986, and December 31, 1988. Second, the project observed twenty mediation sessions

35. See note 34.

36. Particularly helpful in devising the current study have been the writings and insights of John Esser, *Evaluations of Dispute Processing: We Do Not Know What We Think and We Do Not Think What We Know*, 66 Denver U L Rev 499 (1988-89), and Michael Patton, *Creative Evaluation* (Sage Publications, 1981), on evaluation research; Marc Galanter, *Reading the Landscape of Disputes: What We Know and Don't Know (and Think We Know) About our Allegedly Contentious and Litigious Society*, 31 UCLA L Rev 4 (1983); Marc Galanter, *The Radiating Effects of Courts*, in Keith Boyum & Lynn Mather, eds, *Empirical Theories about Courts* (Longman, 1983); Marc Galanter, *The Emergence of the Judge as a Mediator in Civil Cases*, 69 Judicature 257 (1986); Marc Galanter, *The Day After the Litigation Explosion*, 46 Md L Rev 3 (1986); Robert Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 Yale LJ 950 (1979), on lawyer bargaining and negotiation practices; and Peter C. Carstensen, *Two Causes for the Predictable Failure of Contemporary Tort "Reform": Naive Analysis and Ignorance of Institutional Interaction*, 1987 Detroit Col L Rev 975 (1987), on the multi-institutional aspects of medical malpractice incidence, claims, and litigation.

37. Marc Galanter, *Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change*, 9 L & Soc'y Rev 95 (1974); Richard Miller & Austin Sarat, *Grievances, Claims and Disputes: Assessing the Adversary Culture*, 15 L & Soc'y Rev 525 (1981).

38. Marc Galanter originally suggested the image of a "bargaining" pyramid. See Miller & Sarat, 15 L & Soc'y Rev at 544-45 (cited in note 37). See also Stephen Daniels & Lori Andrews, *The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases* (Am Bar Foundation Working Paper #8806, 1988) ("Dispute resolution pyramid" describes the broad pool of medical incidents from which medical malpractice claims against health providers might arise.).

between October 1988 and April 1989. Third, the researchers conducted a series of informal interviews with lawyers, panel members, parties, and others in attendance at the mediation sessions. Finally, the project sponsored a round-table discussion on the mediation system attended by physicians, attorneys, consumers, scholars, mediators, and state policymakers.

C. Early Findings

Preliminary findings provided here fall into three general categories: (1) filing and processing patterns as reflected in available summary reports from the MMPS office and early findings from the specially constructed project data base; (2) a special review of all settled claims occurring between September 1, 1986, and December 31, 1988; and (3) a description of the mediation process as observed in the panel sessions.

1. *Filing and Processing Patterns.* The MMPS office reports provide summary data on claim disposition.[39] As of early 1988, of the first 250 completed sessions, the MMPS appeared to be "settling" or resolving only 9 percent of the claims. In 15 percent of the claims, no settlement occurred and the statute of limitations expired without the claimant filing suit. In 7 percent of the claims, there was no settlement and claimants were still considering suing. The remaining 69 percent of the claims proceeded to court. In approximately half of these claims, at least one of the parties indicated that the mediation had served a "constructive purpose." MMPS reports do not define what "constructive purpose" means, but oral interviews with the MMPS administrator and others participating in the process suggest that this term typically refers to a weeding out of unnecessary parties or to the clarification of legal issues related to a claim.

Table 1 compares this information with that provided in the recent MMPS report of 1989 for the next 150 additional completed claims (for the period ending December 31, 1988). Table 1 not only reveals how few claims settle at mediation, but also indicates that fewer claims are settling over time and that fewer people are finding the process helpful.

39. Reports of the Office of the Director for State Courts, 1987-90 (four reports covering September 1, 1986, to December 31, 1989) (on file with author). These reports must be used with some caution, since they do not fully identify or clarify the types of mediated claims to which the different tables and summaries refer. Complete information about the disposition of all 870 claims mediated since 1986 is not available at this time. However, a quick overview of claims processing is provided in official MMPS summary reports issued annually since 1987 and available in data from the project data base.

TABLE 1

MMPS INFORMATION ON CLAIMS THAT HAVE COMPLETED MEDIATION

		First 250 Claims	Next 150 Claims	Total (400)
A.	Settled at or shortly after session	22 (9%)	6 (4%)	28 (7.0%)
B.	Not Settled, not filed, SL expired	37 (15%)	36 (24%)	73 (18.2%)
C.	Not settled, not filed, SL still running	18 (7%)	−8 (−5%)	10 (2.5%)
D.	Not settled, filed in court but mediation did serve constructive purpose	80 (32%)	43 (32%)	128 (32.0%)
E.	Not settled, filed in court, and mediation did not serve constructive purpose	93 (37%)	68 (45%)	161 (40.3%)

These reports reveal a high number of claims where there is no mediated settlement, no court action has commenced, and the statute of limitations has expired (category B in Table 1). The number of claims in this category increased in the last several months of the period of review; such claims account for almost 20 percent of all filed claims. To some, this indicates that the program has been successful in weeding out frivolous or meritless claims before they get into the system. Parties are presumed to have heeded negative readings from the mediation panel and decided not to press a questionable claim.

This may be occurring.[40] However, it is too early in the study of the mediation program to draw such a conclusion. We simply do not yet know enough about what occurs following mediation and why. For example, it is just as possible that the parties who dropped their claims found mediation of no help, or were prevented from acting for other reasons, for example, lack of adequate legal counsel or finances. Until the interviews and case studies now underway are completed, no conclusions can be asserted on why these claims were not pursued.

2. *Review of Settled Claims.* Available information suggests that the medical mediation panels rarely reach a settlement at the mediation stage. Of 870 claims filed between September 1, 1986, and December 31, 1988, MMPS records indicate that only thirty-five cases (4 percent) reached settlement during or in conjunction with the mediation session.[41] A case is deemed

40. Civil justice research has suggested that increased institutionalization of grievance procedures legitimizes the complaining process, actually increasing the number of grievances and claims voiced, and simultaneously allowing for careful pre-hearings of the claims to expose those that are more meritorious. Meritless claims will be identified and will drop out. Fewer disputes will actually be pursued and there will be higher rates of success for those meritorious claims that stay in the system to completion. See, for example, Miller & Sarat, 15 L & Soc'y Rev at 545 (cited in note 37). Such a theory would be compatible with those who argue the large dropout rate is a success.

41. The inclusion of some of these claims in the settled category seems inappropriate, given what we know about the MMPS process. Parties and their attorneys do not meet with the mediation panel until the date of the hearing. Arrangements for the panel are handled from the Madison office, and parties are generally prohibited from contacting even the attorney-chair of the panel prior to the date of the session. It is possible that the "threat" of going to the mediation session may prove to be a stimulant to settlement, much as the threat of a firm date for trial encourages last-minute

settled by the administrative office when it is fully resolved by an exchange of money at, or within three to four weeks of, the mediation session.[42]

A special review of the settled claims reveals interesting information on the types of cases that have settled. It also points out the malleable nature of the phrase "settled due to mediation" and invites discussion about the negotiating process that seems to be occurring in and around medical malpractice mediation. Settled claims are listed as those that settled at the session (eight of thirty-five), those that settled shortly after the session (thirteen of thirty-five), those that settled prior to mediation (ten of thirty-five), those that were withdrawn by the claimant or dismissed prior to the session (three of thirty-five), and one case that had not settled after two years of having filed the claim but that had been targeted as "likely to settle" by the attorney-chair (one of thirty-five). As Table 2 indicates, over 75 percent of these settlements were classified as "prefiling," that is, prior to commencement of a circuit court action.

TABLE 2

PROFILE OF SETTLED CLAIMS

	Pre-Filing Claims	Post-Filing Claims	Total
Settled at Session	4	4	8
Settled Shortly After Session	11	2	13
Settled Prior to Session	8	2	10
Withdrawn/Dismissed or Session Canceled	2	1	3
Other	1	0	1
Totals	26	9	35

By almost any measure of program settlement rates, the MMPS settlement rate must be considered extremely low. Furthermore, the number of claims settled appears to be declining over time. Twelve of the thirty-five settled claims were filed between September 1 and December 31, 1986, the first four months of operation.[43] Of these twelve, three settled at the session and four settled shortly after the session; all but one were "prefiling" claims. Most of

settlements. But it seems strained to label claims that were withdrawn or settled *prior* to a session as "settled due to mediation." Subtracting these claims, a more likely figure of settled claims is approximately twenty (2.4%), not thirty-five. Nevertheless, until more is discerned about the classification of settled claims, this article will continue to discuss the characteristics of all thirty-five cases deemed settled by the MMPS office.

42. The attorney-chair is supposed to submit a report on the results of the session within one month; most comply. The MMPS office indicates that parties' counsel typically call the panel chair or sometimes the Madison office to notify them of a decision either to settle the claim or litigate in circuit court. Lawyers are required to indicate the latter move in writing to the Madison office; review of available files suggest they rarely do.

43. Between June 1, 1986, and September 1, 1986, when the old PCPs were no longer operating and the MMPS had yet to begin, claimants with pending claims and those with new ones had the option of choosing to go to mediation or directly to state court. Few—some assert only 7-9%—chose to mediate during that period, and many were fearful that there would be a glut of malpractice claims going to county circuit courts starting in June 1987. See, for example, Nathan Heffernan, *State of the Judiciary*, 59 Wis Bar Bull 10 (1986).

these were settled within three to five months, but two took up to one year to settle. Of the last 150 claims to go through the process, only six settled.[44]

An avowed purpose of the MMPS is to settle small claims, and thus it is of interest to look at the settlement amounts of the settled cases. In eighteen instances, the settlement amount was undisclosed. Typical disclosed settlement amounts ranged from $2,000 to $33,300. The highest settlement amount was $600,000—a pro se claim from northern Wisconsin brought against a hospital alleging negligence in the birth of a child born with neurological problems. It would appear that the MMPS did remove several small claims from the system. However, full correlation of settled versus unsettled claims must be undertaken before we can understand why cases actually settled at the mediation stage.

3. *The Mediation Process As Observed.* Observations of mediation panel sessions throughout Wisconsin between October 1988 and April 1989 reveal interesting details on panel operations, the roles assumed by panel members, and the degree of control exercised by claimants, respondents, and attorneys. During these observations, attention was paid to how panel members fulfilled their assigned roles and to the level of participation by claimants and respondents. A brief description of the process as observed, organized by the roles played by participants in the process, is provided below.

a. *Attorney-chairs.* In the cases observed, the panel attorney-chairs exerted great control over the panels and their proceedings. The chairs (they were all men) outlined the purpose, goals, and procedure that panel members were to follow, coordinated the flow of parties and lawyers into the mediation session, and remained in control throughout the session. Most lawyers who served as panel chairs were "repeat players"[45] in two senses of the phrase. Between thirty-five and forty attorneys from the available statewide pool of about eighty-five possible attorney-chairs had served previously on a PCP panel. Thus the MMPS—using its discretion in arranging who will serve as panel chairs—exercised an understandable tendency to return to those lawyers who showed interest and ability in trying to make the system work. Of the available pool of attorneys willing to serve as mediators, a small core group of twenty attorneys actually handled most of the sessions each year.[46]

Most attorney-chairs were experienced personal injury lawyers, roughly split between the plaintiff and defense bars. Most considered their efforts akin to pro bono work, in that the $150 per session fee was significantly less than they could earn in their normal practice in the same time. Attorney-chair

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44. Of the thirty-five claims that MMPS list as settled due to mediation, eleven were from southeastern Wisconsin and eleven were from Madison and southwest Wisconsin; these two regions encompass the largest percentage of the state's population. Seven claims were from west central and northwestern Wisconsin, and six were from east central and northeastern Wisconsin. It is not surprising that the most populous areas of the state produce two-thirds of the state's claims.

45. Galanter, 9 L & Soc'y Rev at 95, 97 (cited in note 37).

46. Three different attorneys chaired ten of the twenty sessions I observed, even though I made a conscious effort to avoid sessions chaired by someone I had already seen.

styles ranged the gamut of available models of lawyer and mediator behavior. Individual characteristics, background, and age certainly accounted for some of these differences. In two instances, the chairs appeared to exceed the limits of propriety or at least of discretion.[47] Some chairs in rural areas were more relaxed, informal, and humorous throughout the sessions, and made a point to talk to the parties and ask them to speak for themselves. This suggests the possibility of regional or local legal culture as a factor in mediating and bargaining patterns.[48]

b. *Physician/hospital panel members.* Physician or hospital panel members typically fulfill their assigned roles ably as the medical expert for their field. In most observed sessions, other panel members and parties' lawyers asked the health members numerous questions about the medical issues presented in the claims. Many physicians drew diagrams to explain medical procedures pertaining to the case at hand, and in two instances the doctors examined the claimants for a visual identification of the alleged injury, after having obtained permission to do so from the claimants and their counsel.

Some doctors specializing in areas within which claims frequently arise were used repeatedly, as were physicians retired from practice. (Fifty percent of the physicians actively serving on the panels are retired.) Some panel physicians appeared to be affected somewhat by their advancing ages. There may be a problem obtaining adequate and reliable physician input, given the voluntary nature of physician service under the present scheme. Physicians who do participate indicated that they do so out of a sense of civic duty and an interest in reducing medical malpractice litigation.

c. *The lay panel member.* The least operational panel member was the lay member, whose role was akin to that of a juror. Rarely did the lay member perform this function with great enthusiasm or insight. In the twenty sessions observed, few lay members asked questions or provided opinions on issues in the cases. In some instances, it was obvious the member had not read the file; many typically spent session time looking over the notes and medical records referred to by the doctor on the panel. In two sessions, the lay members did not speak, and in yet another session the lay member insisted on telling her own lengthy medical history as an analogy to the claim being presented that day. Although not all lay members were uninterested or ineffective, project

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47. In one instance, the chair opened the public session in front of all parties and their lawyers with the statement, "Well, I am not sure why the hell we are here. We all know these mediation panels don't work." In a different session, a different chair made an impolite remark about the claimant in the matter. The claim involved an obese woman who brought suit for an allegedly failed stomach stapling operation because she had not lost weight after one year. In a closed session of the panel, the chair characterized the claim as trivial by saying, "Why should these Docs pay her money when the real problem is she can't stop eating Twinkies?"

48. See Herbert Jacob, *Justice in America: Courts, Lawyers and the Judicial Process* (Little, Brown, 4th ed 1984), for a description of local legal culture in Wisconsin during the early operations of Wisconsin's divorce reform legislation, which required a reconciliation hearing prior to no-fault divorce proceedings.

observations and the comments of many involved in the process suggest that the lay member is not essential to the process.

d. *Parties and their attorneys*. Lawyers for the claimants and respondents were assertive in controlling their clients' participation in the process. In all but two sessions, claimants were present and all were represented by counsel.[49] Some attorneys allowed their clients to speak openly; others did not allow them to speak at all. In about one-third of the sessions, the respondent physician or hospital representative was not present, such absences having been approved for cause by the MMPS office. There was no direct exchange between the claimant and the respondents in any of the observed sessions. The degree to which the respondents spoke at all depended upon the control exercised by the lawyers; when they did speak, it was only in closed session, with the claimant absent.

D. Critiques of the Process by Panel System Participants

Lawyers and their clients commonly cite three major problems with the MMPS. First, claimants' and respondents' lawyers both argue that the lack of discovery limits their ability to find out what happened. According to their argument, mediation thus occurs before sufficient information is available for a reasoned settlement. As a result of inadequate medical information, panel members had difficulty estimating levels of injury, causation, and degree of harm. While possibly reducing costs to the parties, as intended, the prohibition on discovery seems to impede, rather than promote, settlement.

Second, many defense attorneys assert that the statutorily required reporting of any settlement payment by respondents to the State Medical Examining Board inhibits settlement.[50] Some physicians fear retaliation, investigation, and increased malpractice insurance rates if reports are made, regardless of the amount of or reason for the settlement. For this reason, small claims that typically would settle are not settling. While observations did reveal several small claims in which the respondent physician and the attorney for the physician's insurer declined to settle for these reasons,[51] preliminary interview data with physicians who have settled claims via the MMPS indicate their highest priority is to avoid the stress of going to court. Moreover, physicians who are reported to the State Medical Examining Board are not at risk. A recent study revealed that while the number of filings and investigations have increased (due to 1985-86 changes in the law making it

49. These observations are taken from the twenty sessions I observed. Of all the cases I attempted to observe, I was refused access to only one, which involved a pro se claimant.

50. Wis Stat § 655.26.

51. One session involved a seemingly valid claim of physician error in intubation during surgery that had caused severe dental problems needing repair. A claim of $8,000 was about to be settled for half that amount, but at the last minute the respondent's attorney refused to proceed, on the grounds that the claim was unjust and that even that amount of payment would have to be reported.

mandatory), files are still processed slowly, and there is an extensive backlog of cases. Few cases result in disciplinary action.[52]

The third common complaint among participants is the panels' lack of power to enforce their recommendations or decisions, which inherently weakens the process' effect. Since the process is nonbinding, informal, and off the record, some assert that lawyers can simply attend, put in their time, and, in the case of the defense bar, add billable hours.

The assumption is questionable that mediators should be able to enforce a session accommodation or recommendation. That some people think they ought to lends keen insight into commonly held expectations of the process at work in Wisconsin. Lawyers and clients observed in the twenty sessions typically wanted closure, certainty, and a decision; they appeared frustrated by the open-ended process promoted by the mediation panels. Many parties and their attorneys—both those observed and attorneys interviewed—appear to find the advice and opinions of the panel of little value.

At this juncture, one is left with a conundrum: fewer claims are coming each year to the MMPS[53] and most claims that do come for mediation are now filed simultaneously in circuit court. This suggests that fewer attorneys and clients perceive the process to be a viable option before resorting to litigation. MMPS has a very low settlement rate, and over 70 percent of the claims going through mediation end up at least starting the traditional civil litigation process in the state court system.[54]

MMPS may actually be discouraging mediation. Claims may be settled early or be abandoned because MMPS is seen as a waste of time. Settlement may be taking place either on the road to the courthouse steps—just as it always has—or before commencement of any formal claims, without help from the MMPS. Many things remain opaque at this time in the study of the Wisconsin scheme, but at least we know that very little settlement is occurring and that many people feel the system has little positive value.

IV

Analysis and Assessment

The preceding description, albeit preliminary in many respects, suggests that the present operation of the MMPS differs greatly from what one might assume to be a typical mediation process. Unlike most mediation processes, the MMPS allows for little direct party participation, results in few mediated

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52. *Medical Discipline in Wisconsin: No Cure in Sight* (Ctr Pub Rep and Wis Acad Trial Lawyers, April 1989).

53. In 1989, claims filed with the MMPS declined for the third straight year, from a high of 454 claims in 1985 down to 398 (1987), 353 (1988), and 339 (1989). Office of the Director for State Courts, *Status Report* (cited in note 27).

54. All claims that continue in the traditional state court system do not, however, end up in trial. Widely known statistics on civil litigation suggest that nine out of every ten claims are settled before trial, David Trubek, et al, *Civil Litigation Research Project Final Report* (Disp Proc Res Program, 1987), and, in Wisconsin last year, there were less than fifty completed medical malpractice jury trials (oral testimony at the legislative hearings on tort reform (Madison, March 1990)).

settlements, and does little to promote harmony, reciprocal understanding of party needs, or active processes for interaction and joint resolution of problems. MMPS is certainly not mediation in its classic sense. One possibility is that the MMPS has developed a hybrid scheme of mediation peculiar to the medical malpractice context. Jay Folberg and Alison Taylor note that sometimes "the nature of the conflict, the setting, the resources and experience of the disputants, and the background and training of the mediator [can be] so diverse that [mediation] models are illusory [and the] unique demands of the controversy being mediated may require an eclectic approach."[55] The present makeup of the mediation panels—drawing upon its historical ties to the PCP process—has led to an eclectic mediation approach. Even if this is so, few positive attributes can be identified within such a system that leads to so few mediated agreements, allows so little participation for parties,[56] and results in 92 to 97 percent of its claims being abandoned or heading toward the state courts. While there may be interest in settling claims out of court, the parties and attorneys have shown little interest in adopting a mediative approach of the type required to assist in settling malpractice actions.

Two other possible explanations may describe the essence of the MMPS as it currently functions. In one scheme, the panels can be seen as providing what some refer to as "early neutral evaluation" of the case. Early neutral evaluation is generally defined as an objective assessment of the strengths and weaknesses of a case by an impartial panel early on in the proceedings of the case.[57] MMPS guidelines indicate that the panel, if it appears that mediation will not be productive, can ask the parties if they want to hear the panel's opinion on liability and damages. The MMPS office now states that early neutral evaluation is a primary function of the panels, especially as it may apply to those cases that do not settle.[58] The office also reported to the legislature that as of 1988 the panel procedure requires this function.[59] If early neutral evaluation is indeed occurring, MMPS may be providing a useful role in the sorting out of claims. However, project findings indicate that it is still too early to conclude that MMPS operates in this manner. We still have no real explanation of why claims stop at the mediation level, and no conclusive evidence that the panels act as an early neutral evaluation forum.

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55. Folberg & Taylor, *Mediation* at 131 (cited in note 11).

56. Party satisfaction with dispute processing schemes and their attendant results is often asserted as both a positive goal for alternative schemes and a valid measure by which to judge process quality. See Jessica Pearson, *An Evaluation of Alternatives to Court Adjudication*, 7 Just Sys J 420 (1982); compare David Luban, *The Quality of Justice*, 66 Denver U L Rev 381 (1989). Anecdotal evidence and my observations suggest high levels of dissatisfaction with the Wisconsin MMPS, and perhaps even more important, simple confusion about the process in which the participants were involved. In one session I observed, a claimant kept assuming she was being attacked by the panel and kept asking the chair, "When can I defend myself?"

57. See, for example, Wayne Brazil, et al, *Early Neutral Evaluation: An Experimental Effort to Expedite Dispute Resolution*, 69 Judicature 279 (1986).

58. Office of the State Courts, *1988 Status Report* at 3-4 (cited in note 33).

59. See note 33.

Another likely explanation is that lawyers are getting together and settling these cases on their own, within well-known and reliable negotiating parameters. To show a significant role as an innovative processing institution, MMPS would have to prove that it is settling claims at an earlier stage or claims that otherwise would not settle. There is no such conclusive evidence. Moreover, previous discussion of the high numbers of claims that settle before mediation or drop out of the system following the session suggest that lawyers might be increasing negotiation ahead of time, avoiding the MMPS, and resolving claims themselves through standard negotiating and bargaining techniques. Indeed, recent information on the drop in the number of claims filed with the MMPS leads one to surmise that practice patterns are being altered to avoid the MMPS altogether.

V

CONCLUSION

WHAT NEXT FOR WISCONSIN?

Concluding that the Wisconsin panel system does not conform to conventional or even unconventional definitions of mediation does not mean that mediation is inappropriate for medical malpractice claims. Many of the potential justifications for mediation remain intact, even if unfulfilled in Wisconsin.

The present challenge is twofold. First, we must identify the primary goal or goals we want to achieve through the alternative resolution of medical malpractice claims—distinguishing between valid and invalid claims, settling valid claims early to reduce congestion in state courts, saving money for the parties and the courts, and balancing participant interests and needs, or party reconciliation. Second, we must improve existing structures and procedures to allow the system to achieve and promote those goals.

Program reform is never as easy as it appears, and it is early in the evaluation process to begin making such recommendations for retooling the mediation process in Wisconsin. Two possible avenues for program reform—one rights-based and the other interests-based—can be sketched preliminarily. These suggestions make several assumptions both about what might work in Wisconsin and about what the state's goals would be for each redesign effort.

In a rights-based reform, the state's primary goals would remain focused on settlement, cost reductions, and compromise to keep claims from entering the state courts. Because of the apparent lack of interest among attorneys, the medical profession, and others in fostering a climate for mediation, this approach seems reasonable. In this scheme, an emphasis would be placed on providing a fair hearing and discussion of the rights of the parties in the hope that settlement could be reached and litigation avoided. Political realities may limit the prospects for change, but a new focus on the panels as a settlement tool might include: (1) redefinition of the panel process from mediation to a

mandatory negotiated settlement process expressly providing early neutral evaluation; (2) expanded opportunities for discovery, which would provide parties more information at an earlier stage in the negotiation process; and (3) a two-tiered process of panel hearings, which would require a mandatory hearing early in the process after limited discovery and a second mandatory panel hearing prior to trial. This scheme would allow claimants to continue to explore their claims and would demand that the physician-respondents take the claims seriously. At the same time, it requires little of the parties other than two mandatory meetings, and provides the parties an opportunity to meet in the hope that settlement can be reached. This approach emphasizes negotiation and settlement in a rights-based process of exchange and negotiation; it recognizes the role informal settlement processes may still play in complex litigation that typically ends up in private settlements or jury trials, but abandons any attempt to look like mediation.[60]

An interests-based approach would attempt to create a truly mediative approach to medical malpractice claims. It would assume that the primary goal is to provide parties an opportunity to reach a consensual agreement to the claim and reconcile their interests, needs, and feelings in an informal procedure over which they have control. It would allow for substantial input into the process and participation for parties, as opposed to their attorneys; it would encourage early settlement of the issues but allow for mediation at any stage in the overall resolution process. Mandatory mediation under this scheme would require significant changes in the present system. Examples of the necessary changes include the creation of (1) a mediation process in which parties are referred to a neutral, trained mediator, who perhaps would be assisted by a physician who specializes in the area of medicine relevant to the claim; (2) a multileveled process by which mediation can take place in stages, before and after parties have begun formal litigation, thus allowing for different levels of discovery and exploration of the claim; (3) an "opt-out" process for assessing the suitability of claims for mediation, recognizing that some claims are less likely to benefit from mediation; and (4) a process for internal evaluation and program revision.[61]

Both the rights-based settlement and the interests-based mediation schemes retain ample room for variation. Either scheme, carefully crafted, could provide adequate protections for individual rights and public interests and simultaneously give some relief to beleaguered patients, judges, and physicians exhausted by the tension, trauma, and expense of unfortunate medical incidents and medical malpractice litigation. Either scheme would

60. Compare Note, *Mandatory Mediation and Summary Jury Trial: Guidelines for Ensuring Fair and Effective Processes*, 103 Harv L Rev 1086 (1990), for a description of "rights-based mediation." The author indicates that "rights-based mediation focuses on the rights the disputants would have in court . . . and uses those rights to develop parameters within which the parties might resolve the dispute." *Id* at 1088.

61. See Law and Public Policy Committee of the Society of Professionals in Dispute Resolution, *Mandated Participation and Settlement Coercion: Dispute Resolution as It Relates to the Courts* (discussion draft, 1990).

also require a balancing of competing interests and rights and, thus, significant legislative and consumer activity to achieve the sought-after changes. In spite of the difficulties presented, this author remains optimistic about the possibilities of serious reform. There is growing evidence of innovation among the courts and the bar in Wisconsin, evidenced in part by the creation of a new study group on ADR by the State Judicial Council and by the State Bar's new committee on ADR. Medical communities and professional groups are expressing a willingness to explore innovations by means of in-house resolution and conciliation efforts, and the State Office of the Commissioner of Insurance is involving state malpractice insurance providers in an evaluation of claims settlement practices. The question remains whether those involved will be interested enough to accept the challenge of making the alternative resolution of medical malpractice claims an effective—and perhaps truly mediative—process.