THE UNREALIZED POTENTIAL OF MALPRACTICE ARBITRATION

Thomas B. Metzloff*

Although the use of arbitration in the commercial arena has increased tremendously in recent years, there has been a reluctance to adopt arbitration of medical malpractice claims in place of litigation. After discussing the benefits of arbitration in medical malpractice cases, Professor Metzloff examines why the use of arbitration has not become predominant, discussing such factors as judicial hostility, failure of state statutes designed to encourage arbitration, and lack of hard evidence that arbitration works. Professor Metzloff then explores the future of arbitration in medical malpractice cases, citing examples from his own work experience with Duke Law School's Private Adjudication Center, and discusses attributes which would make malpractice arbitration successful in the future.

INTRODUCTION

Those interested in alleviating problems with the current litigation system for medical malpractice cases have long suggested the use of binding, contractual arbitration.¹ In the malpractice context, a number of state legislatures supposedly provided some impetus to arbitration by en-

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During the past five years, I have had the pleasure of working closely with numerous attorneys, malpractice insurers, litigants, and arbitrators. In virtually every instance, they have been cooperative and interested in fairly considering whether to use arbitration or other ADR methods. They have openly shared their concerns and perspectives. I wish to express my appreciation to all of them, but especially to a few. Among the arbitrators with whom I have worked, Robert Collier, Ralph Walker, Robert Browning, Robert Kirby, and Ralph Peeples have demonstrated true judicial independence as well as commitment. Among the scores of attorneys with whom I have worked, I have benefitted greatly from my dealings with Charles Thompkins, John Martin, Grover McCain, William Hamilton, Lee Cheney, Rick Poling, John Edwards, Liz Kuniholm, William Daulett, Jim Fuller, and Charles Burgin. Special thanks are also in order to Wayne Parker and Jim Davis from Medical Mutual and Robert Stonebreaker from St. Paul Insurance Company.

acting malpractice specific statutes designed to facilitate its use. Yet, to date, few malpractice cases have been resolved through arbitration despite the fact that in other litigation contests, such as securities and construction disputes, arbitrations are routine. For example, in Michigan—a state that made a concerted effort to promote malpractice arbitration—a recent study indicated that during a thirteen year period, only 247 malpractice disputes out of a total pool of approximately 20,000 claims were arbitrated. Why has arbitration failed to carry the day in malpractice? What combination of legal, social, structural, and political factors explains this failure? Should the future be different?

I. The Potential Benefits of Malpractice Arbitration

In arbitration, the parties agree to use an arbitrator, usually a privately retained individual or a panel of arbitrators, to render the decision instead of a judge or jury. Arbitration is both a voluntary process in that the parties have agreed at some point to its use, and a binding process that will conclusively resolve the dispute subject to limited appeal rights. Arbitration, unlike other alternative dispute resolution (ADR) mechanisms, is thus not a process designed to promote voluntary settlement. Rather, it is an alternative method of reaching a decision on the merits of the case. In addition, the parties to an arbitration have substantial power to determine for themselves the particular details of the arbitration procedure. Procedural variables relating to the conduct of an arbitration hearing include, among others: the length of the arbitration hearing, the number of arbitrators, the required qualification of arbitrators, the process for selecting arbitrators, and the amount of discovery permitted to be conducted. Significantly, arbitration does not change the basic tort theory of liability; most arbitration clauses require the arbitrators to apply the

2. For a useful review of state legislative efforts, see Irving Ladimer & Joel Solomon, Medical Malpractice Arbitration: Laws, Programs, Cases, 653 INS. L.J. 335 (1977). The failure of a state to enact a specific malpractice arbitration statute does not preclude the use of arbitration; most states have enacted the Uniform Arbitration Act of 1955, which provides a basis for claiming a right to enter into an arbitration agreement.

3. According to one study of malpractice claims closed in 1984, only 0.2% of malpractice claims were decided following arbitration. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984 37 tbl. 2.20 (1987).

4. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: FEW CLAIMS RESOLVED THROUGH MICHIGAN'S VOLUNTARY ARBITRATION PROGRAM 7 (1990). In another example, Alaska also has in place an arbitration statute ostensibly designed to facilitate the use of private arbitrations. ALASKA STAT. § 09.55.535 (Supp. 1992). In fact, however, there is no indication that any malpractice cases have in fact been arbitrated pursuant to that authority. Thomas B. Metzloff, Comment, Alternative Dispute Resolution Strategies in Medical Malpractice, 9 ALASKA L. REV. 429, 438-44 (1992).

5. The parties can agree to arbitration at several different points in the evolution of the dispute. Litigants in a malpractice case can voluntarily agree to submit their claim to binding arbitration in lieu of a jury even after suit is filed. For the most part, however, this article considers the use of binding arbitration where the patient and health care provider agree prior to the rendition of medical care to use arbitration to resolve any disputes that may arise from allegedly negligent treatment.
applicable substantive law. To be sure, however, arbitrators are not subject to the same level of appellate review as judges who are deciding cases and, thus, may have greater flexibility to ignore specific substantive law requirements. 6

A. The Nature of Malpractice: A Brief Description of the Litigation Process and Its Perceived Problems

What, in fact, do we know about the current process for how malpractice disputes are litigated? Fortunately, there has been a relative wealth of empirical studies in the malpractice field, providing a number of specific insights that are helpful in exploring the future of arbitration. 7

Malpractice claims are contentious. Unlike other litigation contexts where pre-litigation settlements are routine, malpractice claims that are pursued tend to be filed in court and are often heavily litigated. While there are some pre-litigation settlements of malpractice claims, they are rare; those claimants that do in fact obtain compensation through settlement do so only after filing a lawsuit. 8 The issues litigated range from liability issues about whether there was negligence, to causation issues, to damage questions. Given that many suits involve serious questions of liability, reliance on expert evidence is heavy.

The highly contentious nature of many malpractice disputes is a function, in part, of the physicians' interest in seeking to "clear their names," which means that many physicians are disinclined to approve settlements. The prevailing view is that most physicians will prefer to litigate to protect their reputations and to avoid any adverse consequences with medical disciplinary authorities. 9 In 1990, the federal government began requiring all malpractice insurers to report any malpractice judgment or settlement to the National Practitioner Data Bank. 10 Hospitals and other interested parties have the right to search the Data Bank to determine a physician's history with respect to successful malpractice

6. For example, the FAA provides for vacatur of an arbitral award only in very limited circumstances. 9 U.S.C. § 10(a) (1994).
8. See James S. Kakalik & Nicholas M. Pace, Costs and Compensation Paid in Torts Litigation 31 (1989) (noting that approximately 90% of the dollars paid to malpractice claimants occurred after a lawsuit was filed). In comparison, only about 33% of the dollars awarded to automobile accident claimants required a lawsuit; the balance of 67% was paid in settlements achieved without the need to resort to a lawsuit. Id.
10. Ilene D. Johnson, Reports to the National Practitioner Data Bank, 265 JAMA 407, 407 (1991); see generally Fitzugh Mullan et al., The National Practitioner Data Bank—Report from the First Year, 268 JAMA 73, 73-75 (1992) (discussing the National Practitioner Data Bank's origin and procedures).
claims. This mandatory reporting makes many physicians hesitant to settle claims absent compelling proof of negligence.

Critics of the litigation system abound, many of them focusing on the role of lay juries in malpractice disputes. Juries resolve a small, but nonetheless significant percentage—about ten percent—of malpractice cases with the balance either being dropped by the plaintiff or settled. Contrary to popular perception, most studies of malpractice trials have shown that physicians prevail most of the time and that juries are reasonably competent decisionmakers at least with respect to the liability issue. Despite the fact that physicians usually win, there is growing concern with the number of large verdicts in favor of some plaintiffs. Even those who are uncritical of juries per se believe that the discretion afforded juries in making awards for non-economic damages such as pain and suffering leads to unpredictability.

There is a litany of widely-shared concerns about the current system. One concern relates to the quality of expert witnesses testifying in malpractice cases. Other concerns relate to what appears to be a high level of non-meritorious cases; the best current empirical evidence suggests that the percentage of non-meritorious malpractice claims is substantial, probably near the forty-percent level. Still other concerns are the expense and delay seemingly inherent in the current system. For these reasons and others as well, the litigation system is difficult for potential plaintiffs to access. The extent of the difficulty was recently quantified in a major study conducted by researchers at Harvard University. A principal finding of the study was that the number of malpractice claims actually asserted falls far short of reaching the actual level of negligently-

11. Mullan et al., supra note 10, at 73-75.
12. Gross & Syverud, supra note 9, at 362.
17. See Peter W. Huber, Galileo’s Revenge: Junk Science in the Courtroom 14 (1991) (questioning the credibility of professional expert organizations).
19. See, e.g., Metzloff, Resolving Malpractice Disputes, supra note 14, at 63-69 (detailing the high cost of jury trials).
20. The Harvard Study results have been published in numerous sources. The most complete account is Paul Weiler et al., A Measure of Malpractice (Harvard 1993).
inflicted injuries.21 The Harvard Study calculated that, assuming that all lawsuits filed involved actual cases of negligence, at best only about one in eight potential claims ripened into a lawsuit.22 Rather than there being too many cases, there is, in fact, serious underlitigation of malpractice claims.23

Nonetheless, the empirical information relating to those claims that are litigated has led many observers to conclude that the current system, while flawed, works reasonably well.24 By and large, all of the players in the system appear to be doing the best that they can to make it work. The system appears to be resolving most cases appropriately. The fact that many see continuing problems in the system is perhaps more a reflection of the inherent difficulty of the task assigned to the litigation system: determining negligence from non-negligence in the context of many malpractice suits is an inherently difficult process.

Another salient fact about malpractice litigation is its high visibility. Perhaps no other litigation area has been the subject of as much interest in reform over a longer period of time as medical malpractice. A distinct element of this interest has been efforts to change the process by which malpractice cases are handled. Since the mid-1970s, virtually every state has attempted some type of “tort reform” intended to impact how medical malpractice suits are handled.26 Many of these proposed changes involved procedural changes that were designed to limit claims, such as the reduction in statute of limitations periods,26 restrictions on plaintiffs’ attorneys’ contingency fees,27 and the creation of screening panels to review malpractice claims prior to the filing of a lawsuit.28

21. Id. at 12.
22. Id. at 13.
23. Id. at 13-14.
24. See also Metzloff, Resolving Malpractice Disputes, supra note 14, at 82-83 (finding that jury outcomes on liability issues were predictable and generally in line with insurer assessments of whether a physician was negligent); Mark I. Taragin et al., The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims, 117 ANNALS OF INTERNAL MED. 780, 781 (1992) (finding that the payment of damages occurs much more frequently when physician care is indefensible).
26. See FRAMEWORK FOR ACTION, supra note 25, at 21 (recommending shorter statutes of limitations).
27. See id. at 22-24 (recommending limits on attorneys’ fees); cf. Weiler, Medical Malpractice on Trial, supra note 25, at 62-64 (suggesting that limiting contingency fees is not an appropriate solution in an adversarial system).
28. See Schor, supra note 1, at 69-70 (outlining the advantages and disadvantages of screening panels).
B. The Potential Benefits of Arbitration

Given the above, what are the potential benefits of arbitration? The following is a thumbnail sketch of relevant potential positives. Primary perceived benefits of arbitration for malpractice that are routinely cited include employing more qualified decisionmakers, reducing litigation expenses, alleviating the trauma of malpractice litigation, and potentially reducing problems with experts.

1. Employing more qualified decisionmakers

Many arbitration advocates question the ability of lay juries to decide complex malpractice disputes and have looked to ADR to provide a more qualified decisionmaker. Since such cases usually involve matters of medical practice, some have suggested that doctors be routinely included. Interestingly, early arbitration efforts, codified in many of the malpractice specific arbitration statutes passed in the 1970s, required the inclusion of physicians on the arbitration panel. Such a provision often became the focal point of legal challenges because of the perceived bias of the physician member. Provisions establishing specific arbitration requirements are unusual; the norm in arbitration is to permit the parties flexibility in devising the procedural parameters of the arbitration.

2. Reducing litigation expense

Malpractice litigation is undoubtedly expensive. The best available evidence indicates that the costs of litigating malpractice disputes exceed the amount paid in compensation to injured plaintiffs. Arbitration, in theory, saves time and money. If administered properly, arbitration offers the potential for significantly shorter “trial” time. The length of malpractice trials varies considerably; recent evidence suggests that the median trial length is five days, but a significant number of much longer trials occur. Arbitration hearings can be shorter in part because there is no need to select, instruct, or manage a jury. In addition, conflicts over evidentiary issues are minimized because arbitration hearings are typically less formal than a jury trial. In addition, arbitration hopefully reduces the amount of discovery required.

29. For a discussion of state arbitration legislation, see infra pt. II.B.
31. See KARALIK & PACE, supra note 8, at 41, 54 (noting that costs and expenses incurred by malpractice plaintiffs constituted approximately 36% of the amount recovered, while aggregate defense costs were approximately 30% of the amount awarded in compensation). The high costs are at partly a function of the use of lay juries as decisionmaker; the trial itself represents a major portion of the litigation expenses associated with malpractice disputes. See Metzluff, Resolving Malpractice Disputes, supra note 14, at 53-59.
32. See Metzluff, Resolving Malpractice Disputes, supra note 14, at 49-50.
3. Alleviating the trauma of malpractice litigation

Traditional malpractice litigation takes an emotional toll on the parties, particularly the doctor accused of malpractice. Physicians perceive suits as allegations of almost criminal misconduct. Arbitration potentially mitigates the emotional costs by being more private as well as less lengthy. Arbitration may also diminish the time away from the physician’s practice or the plaintiff’s job.

4. Arbitration and experts

One of the most intriguing potential benefits of arbitration is the possibility of improving the quality and use of expert witnesses. Experts play a crucial role in malpractice litigation: in virtually every case, the opposing parties must have experts to testify as to the applicable standard of care. In addition, medical experts often testify about causation issues. The extensive use of experts poses a number of problems. These problems center upon the expense associated with experts and concerns about the quality of some of the experts. Arbitration agreements could respond to both concerns by, for example, limiting the number of experts that either party should use; or requiring testifying physicians to have demonstrably more relevant expertise than permitted under current court rules. The medical profession and commentators frequently complain about the low quality of experts who testify on behalf of plaintiffs. The current rules of evidence are loose; the current litigation system places substantial faith in the adversarial process to deprecate “hired gun testimony.” Arbitration rules could be devised to install requirements to ensure the quality of the expert evidence submitted in court. Certainly, such a provision would draw opposition, especially from those who believe there still exists a conspiracy of silence among physicians that serves to keep otherwise qualified experts from testifying against a fellow doctor.


34. Experts also testify on damages, but typically they are not medical experts. Instead, rehabilitation specialists and economists are common experts on such points.

35. See HUBER, supra note 17, at 75-91 (providing an example of the quality of expert testimony in obstetrical malpractice cases).

36. Some commentators have suggested a standard that only scientists whose relevant work has been published in refereed journals should be permitted to testify. Is it appropriate to establish so high a threshold for expert testimony? While some malpractice cases do pose complex and challenging issues of medical science, many—indeed most—present more straightforward questions of science where the disagreements turn on factual disputes about what was done. The danger of toughening the expert standards too much is to risk denying access to competent experts for both parties. In many cases, there is no compelling need to have the most renowned expert testify on cutting edge developments; often, the issue is simply to understand what occurred and what was supposed to have been done.

While undoubtedly there are some physicians who refuse to testify against a fellow doctor as a matter of principle, it is almost certainly the case that other physicians prefer not to testify because the litigation system is too wasteful of their time. This conspiracy of annoyance may be reduced in arbitration if experts' time can be better managed. In light of the Supreme Court's recent decision in Daubert v. Merrell Dow Pharmaceuticals, it would seem possible to empower arbitrators to screen experts. In Daubert, judges were urged to undertake "a preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and of whether that reasoning or methodology properly can be applied to the facts in issue." As part of an arbitration procedure, some sort of hearing officer could play the same role to provide an early decision as to the validity of a litigant's expert theories. Such a procedure would parallel in part the availability of the summary judgment rule in traditional litigation. Another intriguing possibility is the potential use in arbitration of neutral experts. There would appear to be no reason why a set of arbitration rules could not establish a mechanism for the appointment of a neutral, non-adversarial expert. Courts currently have the power to make such appointments; while still exceedingly rare, the power has been employed occasionally in the malpractice context.

II. EXPLAINING THE LACK OF USE: WHY HAS MALPRACTICE ARBITRATION NOT BECOME PREDOMINANT?

Given the wide-ranging concerns with the litigation process and the perceived potential benefits of arbitration, the question naturally arises as to why arbitration has not come to dominate the medical malpractice landscape as it has in so many other litigation contexts. Why has malpractice arbitration failed to establish anything more than a foothold? Despite increasingly clear legal authority that would seem to permit the routine referral of malpractice disputes, relatively few malpractice disputes have, in fact, been arbitrated.

Based on my experiences, I offer the following series of explanations. As will be obvious, these differing explanations cannot all be simultaneously true. For example, it cannot be the case that an arbitration system, on the one hand, is inherently derogatory of patient's rights, while, on the other hand, it is likely to result in an explosion of successful and lucrative awards to plaintiffs. Nonetheless, both positions have their adherents. The combination of these explanations reveals the difficult challenges

specific qualifications for expert witnesses because of the general difficulty of finding physicians to testify against colleagues).

39. Id. at 2796.
40. See Fed. R. Evid. 706.
that lie ahead for developing arbitration programs in the current malpractice climate.

A. Judicial Hostility and Legal Uncertainty

It is conventional wisdom that part of the lack of use of arbitration is a function of judicial hostility to malpractice arbitration. To be sure, there are cases from the mid-1970s and 1980s relying on such contract notions as the unconscionability doctrine to void or significantly modify malpractice arbitration agreements. These cases no doubt created an obstacle. One of the supposed benefits of arbitration is to avoid prolonged preliminary disputes. If plaintiffs can routinely challenge the validity of an arbitration agreement on a case-by-case basis, a major advantage of arbitration has been denied.

Regardless of the degree to which these early cases interfered with the development of arbitration, an argument could be made that recent United States Supreme Court and state cases authorizing the routine use of arbitration have removed any real doubt about the availability of arbitration even in the malpractice context. Nonetheless, issues about the basic validity of malpractice arbitration continue to be raised. Recently, the California Supreme Court granted review of a case that challenges the underlying legality of the arbitration program operated by Kaiser Permanente, the acknowledged leader in requiring malpractice arbitrations. Other courts continue to entertain claims that malpractice arbitration clauses are unconscionable under particular facts indicating overreaching by health care professionals.

42. WEIBEL, MEDICAL MALPRACTICE ON TRIAL, supra note 25, at 102 n.25.
43. See, e.g., Obstetrics & Gynecologists Ltd. v. Pepper, 693 P.2d 1259, 1261 (Nev. 1985) (holding arbitration agreement patient was required to sign before receiving treatment was unenforceable); Roberts v. McNamara-Warren Community Hosp., 360 N.W.2d 279, 281 (Mich. Ct. App. 1984) (holding arbitration agreement unenforceable where defendant did not show that plaintiff "knowingly, intelligently, and voluntarily waived his or her right to court access"). See generally Mary Bedikian, Medical Malpractice Arbitration Act: Michigan's Experience with Arbitration, 10 AM. J.L. & MED. 287 (1984) (reviewing early case law under Michigan arbitration statute).
45. Engalla v. Permanente Medical Group, Inc., 43 Cal. Rptr. 2d 621 (1995), review granted 905 P.2d 416 (Cal. Nov. 2, 1995). Prior to that decision, the California Court of Appeals had vacated an arbitration award in favor of a health care provider because the neutral arbitrator in a three-person panel did not disclose that he had served as a party-arbitrator for the health care provider in previous malpractice arbitrations. See Neeman v. Kaiser Found. Hosp., 11 Cal. Rptr. 2d 879 (1992). While not a frontal assault on the validity of arbitration in malpractice, it represents a judicial willingness to scrutinize how such arbitrations are conducted, thus erecting another perceived obstacle to its use.
B. The State Statutes Ostensibly Designed to Promote Arbitration in Fact Did Nothing of the Sort

In retrospect, many of the malpractice-specific arbitration statutes based during the first wave of malpractice "reform" measures in the 1970s in fact did little to promote—and indeed may well have served to limit—the use of arbitration. In Michigan, for example, the malpractice arbitration statute details the specific form that arbitration hearings must follow, thus defeating one of the essential purposes of arbitration—party control over a flexible procedure.\(^{47}\) Georgia's provision is even more restrictive in that the malpractice arbitration agreement will be enforced only if the claimant's consent is after the date of the physician's alleged negligence and only if the patient has consulted with an attorney.\(^{48}\) A statute that truly promotes malpractice arbitration would simply need to announce that the public policy of a particular state was to encourage the use of arbitration under the same flexible rubric that defines the FAA.\(^{49}\)

But again, these statutes cannot fully explain the limited use of arbitration. Most states do not have specific statutes, and thus health care providers in such states could rely on the general authority of the generic state arbitration statute or even perhaps the FAA. Even the most restrictive statutes could be challenged now relying on the logic of Allied-Bruce Terminix Companies, Inc. v. Dobson.\(^{50}\) So one must still delve much deeper under the apparent reticence of the health care industry to push to adopt arbitration.

C. High Comfort Level with the Current System

Malpractice insurers and defense counsel are clearly repeat players in the litigation system. As such, they are cognizant of the many potential advantages that the litigation system affords to malpractice defendants. Thus, while physicians may be highly critical of juries, insurers and defense counsel may be less so. Aware of the results partially revealed by the empirical information described above, insurers and defense counsel are understandably reticent about trading the known quantity of the current litigation system for what is the unknown of arbitration. This comfort level is not necessarily inherently nefarious; it is, in part, simply a recognition that the current system provides extensive opportunities for defendants to obtain the vindication that many physicians in fact seem to desire. By the same token, it is also clear that in some instances at least,

\(^{47}\) Mich. Comp. Laws § 600.5044(2) (1987) (requiring the use of three arbitrators, one of whom must be a physician).


\(^{50}\) 115 S. Ct. 834 (1995). The Court reasoned that the FAA's use of the phrase "involving commerce" instead of "in commerce" as used in other statutes, meant that Congress intended the Act to reach more than "only persons or activities within the flow of interstate commerce." Id. at 893.
malpractice insurers are in a better position than patients to use the inherent expense associated with the current litigation system to create incentives for plaintiffs to drop cases or to settle cheaply. 51

D. Perceived Need for Active Judicial Involvement

Related to the previous point, malpractice defendants also appreciate the high level of involvement that malpractice cases collectively have within the court system. Many of the procedural tools available through the court system in fact provide opportunities for strategic advantage. For example, one benefit of having cases proceed in court is the availability of the judge to resolve discovery motions or motions for summary judgment. These are not trivial concerns. Such motions are relatively common in malpractice cases and are often successful in either narrowing the issues or resulting in outright victories for defendants. While arbitration forums must provide some mechanism to resolve discovery disputes, the procedures for such matters are not well understood. Additionally, in arbitration there is no clear analog for a summary judgment motion. Instead, the norm is that the matter proceeds to the arbitration hearing where non-meritorious cases will be so adjudged.

Similarly, defense counsel may in some cases benefit by the active involvement of judges in promoting settlements, a role not typically played by arbitrators. 52 Defenders may also value procedural rules designed to sanction attorneys or parties for filing non-meritorious claims; 53 arbitrators, even if they have the power to sanction parties, rarely engage in such considerations.

E. The Lack of Empirical Information Indicating That Arbitration “Works”

Those potentially interested in using arbitration to date have not received any impetus from empirical studies showing that the perceived benefits of arbitration are in fact attainable. Empirical research on the impact of arbitration on malpractice cases is sparse primarily because so few malpractice cases have been submitted to arbitration. Not surprisingly, empirical analyses of tort reform measures have generally found that the existence of a malpractice arbitration statute did not have a sig-

51. WEILEK, MEDICAL MALPRACTICE ON TRIAL, supra note 25, at 53-54.
52. See Fed. R. Civ. Pro. 16 (noting that one purpose of pre-trial conferences is to consider prospects for settlement). There is abundant literature on judicial involvement in the settlement process. See, e.g., Judith Resnik, Managerial Judges, 96 Harv. L. Rev. 374 (1982) (discussing increased involvement of judges in case management); American Law Institute Study on Paths to a “Better Way”: Litigation, Alternatives, and Accommodation, 1989 DUKE L.J. 811, 819-20 (discussing the judicial role in case settlement).
53. See generally Sheila L. Birnbaum, Physicians Counterattack: Liability of Lawyers for Instituting Unjustified Medical Malpractice Actions, 45 FORDHAM L. REV. 1003 (1977) (discussing the effect of sanctioning rules on the judicial system). These efforts, however, have proven largely unsuccessful, but again, they are procedural weapons available in court, and much less available in arbitration.
nificant impact. Nor is there compelling empirical information from other arbitration contexts to contribute much to the inquiry.

The scant evidence that does exist suggests that the arbitration process is not inherently pro-physician as some have contended. A recent study by the United States General Accounting Office (GAO), for example, found that plaintiffs prevailed slightly more often in arbitration than traditional litigation and that the process was less time consuming. Surprisingly, however, the GAO study found that the average cost to the litigants of resolving the cases were comparable, and not cheaper as had been expected.

Is there more information potentially available? There is at least one HMO which has extensive experience with arbitration over an extended period of time. Kaiser Permanente Health Maintenance Organization (HMO) has used arbitration as the exclusive remedy for its subscribers in California since the mid-1970s. To date, however, Kaiser has not permitted a detailed analysis of the outcome of its experience. More general accounts suggest that the arbitration leads to quicker results and that plaintiffs achieve similar or even better results than in the trial system. By the same token, however, without more rigorous empirical scrutiny, these generalized assessments lack any predictive force.


55. Empirical information about arbitration in other contexts is not much more available. Even if good information did exist, there would be serious questions about its applicability to medical malpractice disputes which raise far different issues than those raised in a typical commercial dispute.

56. See Irving Ladimer et al., supra note 54, at 433 (finding that arbitration tends to skew results in favor of plaintiffs with severe permanent disabilities as compared to those claimants with minor injuries); see generally Stephen Zuckerman et al., supra note 54, at 85, 103-06 (summarizing available empirical information on arbitration results); Kevin M. Clermont & Theodore Eisenberg, Trial by Jury or Judge: Transcending Empiricism, 71 CORNELL L. REV. 1124, 1137 tbl.3 (1982) (finding that malpractice plaintiffs prevailed more often in federal court cases tried by the judge than in cases tried to a jury).

57. See U.S. GEN. ACCOUNTING OFFICE, supra note 4, at 8 (noting that plaintiffs prevailed in 22% of arbitrated cases as compared to 18% in traditional litigation); see also Clermont & Eisenberg, supra note 56, at 1137 tbl.3 (finding that malpractice plaintiffs prevailed more often in federal court cases tried by a judge than in cases presented to a jury).

58. U.S. GEN. ACCOUNTING OFFICE, supra note 4, at 8.


60. Felsenthal, supra note 59, at B1.
F. The Perception That Arbitration Does Not Substantially Address the Fundamental Flaws of the Litigation Process

Arbitration in and of itself does not radically change how a dispute is litigated apart from the identity of the decisionmaker. Discovery may be somewhat limited and the hearing itself is hopefully shorter. But beyond such tinkering, the use of an arbitration format does not usually alter many of the procedural elements that malpractice defendants find objectionable. For example, arbitration is not thought of as a means to limit plaintiff's attorneys' contingency fees, to impose more effective offer of settlement rules, or to develop more elaborate cost-shifting mechanisms, all of which are pet theories by particular malpractice critics of what is wrong with the current system.

Nor does the use of arbitration in and of itself solve the uncertainties inherent in the process of determining pain and suffering. To be sure, it changes the decisionmaker, moving from a panel of jurors to an arbitrator or panel of arbitrators. But without some additional change in the applicable substantive law to be applied, the arbitrators must make the same subjective determination about the value of non-economic damages as are made by jurors. While some would argue that arbitrators are less likely to make a runaway award of the type that juries are occasionally accused of making, a counterargument exists that because of their own higher incomes and sophistication, arbitrators may tend to award more money in certain cases because they value interference with the enjoyment of life in greater absolute dollar terms than lay jurors.

These concerns are apparent in looking at the American Medical Association's (AMA) single major foray in the ADR field. In 1989, the AMA recommended the adoption of a fault-based administrative system to replace on a state-by-state level the current litigation system. The AMA's proposal includes elaborate procedural steps such as an initial review and investigation by a claims processor, referral to a neutral expert, assignment of a "court-appointed" attorney, mandatory settlement offers, submission of the dispute to a hearing examiner, and review of substantive

61. See, e.g., Weiler, A Measure of Malpractice, supra note 20, at 65 (basing percentage on stage of resolution); Lester Brickman, Contingent Fees Without Contingencies: Hamlet Without the Prince of Denmark?, 37 UCLA L. Rev. 29, 126 (1989) (advocating proportionality between attorneys' risk and reward in contingent-fee cases).


63. For a detailed description of the system and an explanation of the rational of the proposed approaches, see Kirk B. Johnson et al., A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims, 42 Vand. L. Rev. 1365, 1379-84 (1989). The AMA had hoped that at least a few states would adopt the essentials of their proposal; to date, none have.
decisions by an overseeing board. These procedural steps went well beyond what is typically involved in an arbitration. In addition, the AMA proposed a number of substantive law changes such as limiting the total award of non-economic damages. The magnitude of the proposal speaks volumes about the AMA's perceived need to do more than simply replace jurors with arbitrators.

Certainly for many academics as well, arbitration is not seen as a meaningful solution to the problems of malpractice. Arbitration, even if done well, is perceived as little more than a band-aid that would cover up the far more serious shortcomings associated with a fault-based system for dealing with iatrogenic injuries. Most academic critics of the system would prefer far more significant reform of the controlling liability principles often towards some aspect of no-fault compensation. Thus, even ardent critics of the litigation system do not necessarily suggest the use of arbitration as a solution.

G. Pursuing Other Agendas: Understanding Policy Priorities

Policy leaders within the medical establishment have not made arbitration, or ADR for that matter, a priority in recent years; it is a relatively low-level concern among those interested in pursuing tort reform options. As a policy choice, arbitration must be considered in a political context in which a host of policy alternatives are being simultaneously considered. Put simply, the AMA is at this point far more interested in establishing meaningful caps on damages than it is in developing ADR programs. Based upon its assessment of the effectiveness of various options, the AMA has determined that caps offer the most bang for the buck.

H. Perceived Failure of Past ADR Initiatives

Defenders have also been turned off from pursuing arbitration by the perceived past failures of other ADR efforts in alleviating the problems of malpractice. The foremost example is the general experience of those

64. See Johnson et al., supra note 63, at 1379-89.
65. Id. at 1386-87.
66. See Weiler, Medical Malpractice on Trial, supra note 25, at 1-16 (discussing the problems associated with the current system).
68. See, e.g., Walter K. Olson, The Litigation Explosion: What Happened When America Unleashed the Lawsuit 303-05 (1991) (recommending a host of procedurally-based reforms, but rejecting the notion that juries should be replaced).
69. For a valuable discussion of the reasons explaining the agenda of physician groups in the current political environment, see Eleanor D. Kinney, Malpractice Reforms in the 1990s: Past Disappointments, Future Success?, 20 J. Health Pol'y, Pol'y & Law 99 (1995).
70. Weiler, Medical Malpractice on Trial, supra note 25, at 29 (noting that courts
states that adopted, at the urging of the medical profession, "pre-trial screening panels" for medical malpractice cases primarily in the mid-1970s. These early ADR procedures typically required plaintiffs to submit their claims to a special panel, often composed of a physician, attorney, and lay member. The panels issued non-binding decisions which would, in theory, convince the parties either to drop or settle the claim. Either party could insist upon trial by jury, although some states made the panel's finding admissible at the subsequent trial. A common criticism of the panels is that they were administratively cumbersome and that they often lead to long delays. Other concerns were that the process came too early in the evolution of the claim before the parties had conducted sufficient investigation. The conventional wisdom is that these panels, which looked something like arbitration panels, were ineffective in impacting the culture or reality of malpractice litigation; indeed, several states have recently abandoned their programs.

I. Proponents of Other ADR Forms

Even those who are ADR evangelists do not necessarily support the use of binding arbitration. Some avid ADR proponents may well prefer other alternatives. For example, one area of rapid growth in the ADR field is the development of court-sponsored ADR programs. Concerned with burgeoning dockets, numerous state and federal courts have initiated mandatory, non-binding ADR procedures. Several of these models and commentators have "questioned the mechanics, the effectiveness, and the constitutionality of these boards"). Despite the fact that different ADR options involve quite different approaches, there is a tendency among some observers to equate all such programs as a singular alternative. As such, the question becomes not whether arbitration might be a superior method for resolving claims, but rather where ADR is better as a general proposition.

72. Id. at 185.
73. Id. at 212-16.
74. Id. at 260 n.101 (citing B. Furrow et al., Health Law 312-13 (1987)).
75. Existing empirical studies were mixed, with some indications that screening panels do indeed screen out low merit cases, but perhaps only because more claimants elect to assert a claim before the panels. Useful empirical studies include J. MARDFIN, MEDICAL MALPRACTICE IN THE STATE OF HAWAII (1989) (discussing experiences with the Hawaii screening panel system); Stephen Shmanske & Tina Stevens, The Performance of Medical Malpractice Review Panels, 11 J. Health Pol'y, Pol'y & L. 525 (1986).
77. For an excellent overview of characteristics and performance in federal court-ordered arbitration programs, see Bárbara S. Meierhofer, FED. JUD. CENTER, COURT-ANNEXED ARBITRATION IN TEN DISTRICT COURTS (1990). This particular ADR method is usually targeted at minor disputes, and as a result, experience with handling malpractice disputes is quite limited.
are at least potentially attractive in the malpractice context. Such ADR initiatives have the advantage of not engendering such active opposition from patient advocates since these programs are non-binding, meaning that the plaintiff can obtain a traditional jury trial if desired, and because they fall under the supervision of the court. A malpractice ADR enthusiast may prefer these forms to binding arbitration. Still others who believe in the desirability of litigation alternatives would rather invest their time and energy not in arbitration, but in alternative systems seeking early identification and resolution of potential claims. Such approaches would rely on the use of mediation rather than arbitration. The mediator's role is primarily to facilitate the parties' understanding of the nature of the dispute and to explore practical solutions, even if those solutions are not necessarily required by applicable substantive law principles. A mediator, unlike an arbitrator, does not make a binding decision on the merits. Mediation is generally thought to be particularly well suited to disputants with a long-standing past relationship who desire or otherwise need to maintain a working—if not necessarily cordial—future relationship. While experience with mediation in malpractice disputes is limited, it is actively promoted by many malpractice ADR advocates.

The plethora of ADR options leads many adherents to prefer a voluntary approach as opposed to the mandatory referral inherent in a contract requiring arbitration. For some, the use of mandatory arbitration is

78. In addition to the court-ordered mediation programs mentioned, two other ADR processes are worthy of mention here. The first is early neutral evaluation, which calls for an assessment of the case by an experienced neutral attorney on the basis of brief presentations by the parties early in the case. See Wayne D. Brazil, A Close Look at Three Court Sponsored ADR Programs: Why They Exist, How They Operate, What They Deliver, and Whether They Threaten Important Values, 1990 U. CHI. LEGAL F. 303, 334-35. The theory is that the parties will benefit by the evaluator's neutral assessment of the value of the case and reconsider their positions. The second is court-ordered arbitration, a process by which certain disputes are channeled to a non-binding arbitration process following the completion of designated period of discovery. As with the other ADR methods, the details of how specific programs operate varies substantially.


80. See, e.g., James W. Reeves, ADR Relieves Pain of Health Care Disputes, 49 DISR. RESOL. J. 14 (1994); Karl A. Slaikent, Designing Dispute Resolution Systems in the Health Care Industry, 5 NEGOTIATION J. 395 (1989); Ann J. Kellett, R.N., Comment, Healing Angry Wounds: The Roles of Apology and Mediation in Disputes Between Physicians and Patients, 1987 J. DISP. RESOL. 111. For several years, Wisconsin has unsuccessfully employed a hybrid procedure that is ostensibly labeled as a mediation process. See Catherine S. Meschievits, Mediation and Medical Malpractice: Problems with Definition and Implementation, LAW & CONTEMP. PROBS., Winter 1991, 155, 201-11. More recently, several states have enacted legislation empowering trial court judges to mandate the use of mediation in any civil dispute including malpractice cases. See, e.g., FLA. STAT. § 44.102 (1994). While these programs were not specifically designed for malpractice cases, judges have routinely referred malpractice cases to mediation under these programs.
simply substituting one inflexible method for another. They see the challenge of ADR as learning how to choose intelligently among a range of procedures—to "fit the forum to the fuss." Each of the different procedures may be better suited to certain types of malpractice disputes. If true, then realizing the full benefits of ADR requires a careful matching of specific malpractice disputes with the particular ADR process best suited to that case. Also, it may be that there are some malpractice cases best suited to traditional litigation, so that the routine use of arbitration is unwise.

J. Letting the Genie Out of the Bottle: The Fear That Arbitration May Work Too Well

The malpractice insurers’ lack of interest also represents, in part, a concern that if a truly expedited process for asserting malpractice claims were established, the number of malpractice claims would skyrocket. It is generally thought that health care providers would be the beneficiaries of arbitration, based in large part upon the fact that those providers were the ones who initially raised the idea. This simplistic notion is no longer uncritically accepted. The interest in developing binding arbitration has no doubt been cooled by recent evidence of the large, currently untapped pool of potential malpractice claims. While earlier empirical evidence from the 1970s established the same point, prior to the publication of the Harvard Project’s data in the 1980s, the working assumption was that there were too many malpractice cases being filed and that plaintiffs were routinely prevailing in non-meritorious cases. Arbitration could solve that problem by providing a quality system that would quickly deal with what was a large cohort of non-meritorious claims. The Harvard study changed the perception—the real situation is not that there are too many claims being asserted, but in fact too few. Moreover, the available empirical evidence did not support that plaintiffs routinely won their cases. This insight logically requires rethinking of the premise of arbitration as a means primarily of limiting the filing of meritorious suits. If an effective and efficient arbitration system were in fact developed, plaintiffs now excluded from the current system may find it easier to file claims and pursue claims.

81. It is important to note, however, that an ADR clause in a patient-physician agreement need not be limited solely to arbitration. Such ADR clauses can require multi-step ADR in which the parties are required first to submit their dispute to a non-binding process such as mediation and then arbitrate only if the mediation process was unsuccessful.

82. Cf. Maurice Rosenberg, Resolving Disputes Differently: Adieu to Adversary Justice, 21 CREIGHTON L. REV. 801, 809 (1988) ("[T]he ideal system will require deploying a whole battery of dispute-resolving mechanisms, variously directed, variously driven and variously employed.").

83. See Weiler, A Measure of Malpractice, supra note 20, at 137.

84. See, e.g., Paul C. Weiler, Fixing the Tail: The Place of Malpractice in Health Care Reform, 47 RUTGERS L. REV. 1157, 1164 (1995) [hereinafter Fixing the Tail].
K. Perceived Weakness in the Culture of Arbitration: “Splitting the Baby” Concerns and Other Problems

Some malpractice defenders do not have sufficient faith in the process of arbitration to seek routine submission of malpractice disputes. Anecdotal experiences from the few malpractice cases that have been arbitrated or from other arbitration contexts have served to give them serious pause. Perhaps the most widespread concern is that arbitrators tend to make compromise decisions that do not fully vindicate their clients’ interests.85 Especially in malpractice where physicians are often interested in vindicating their conduct, the perception that arbitrators “split the baby” represents a serious, potential difficulty.86 Another widely-held notion about arbitration is that it can be “just as expensive” as regular litigation.87 Other anecdotal accounts criticize arbitrators who step in to help unprepared plaintiffs or who feel compelled to make some award to a plaintiff regardless of the proof offered.

L. Strong Anti-Arbitration Sentiment by Plaintiff Advocate Groups

Plaintiffs’ advocate groups continue to strongly oppose the use of binding arbitration in most contexts, including medical malpractice.88 Why is this position held so strongly despite the clear evidence that the current system hardly operates to the benefit of patients? Certainly, as noted above, there is no valid empirical basis for plaintiff advocates at this point to tar and feather malpractice arbitration. Upon reflection, it is no wonder that the public’s perception is that arbitration is a loaded pistol being aimed at its head by physicians given how the issue has been presented. The primary proponents of malpractice arbitration have been members of the medical profession who, at the same time as they tout arbitration, have been forwarding a panoply of other tort reform options such as caps on damages or other measures to restrict access.89 It has not been presented as a neutral and informed suggestion for improving the overall quality of how malpractice disputes are resolved.90 In the simplistic nature of the tort reform debates, patient advocates are against it be-

86. Id.
87. See, e.g., Alan Bloom et al., Alternative Dispute Resolution in Health Care, 16 Whittier L. Rev. 61 (1986) (comments of participants in symposium critical of the expense associated with arbitration noting that the minimum hourly rate for retired judges serving as arbitrators is $300).
89. See Thomas B. Metzloff, Understanding the Malpractice Wars, 106 Harv. L. Rev. 1169 (1993) (discussing the highly political nature of the extended malpractice “litigation reform” debates).
90. Id. at 1192.
cause doctors are for it; arbitration has become a prisoner of war. The general suspicion with which consumer groups view arbitration is also based on the fact that contractual relationships of this sort are not necessarily limited to procedural as opposed to substantive law changes. They are concerned that arbitration clauses will be used as a front to mask more direct assaults upon plaintiffs’ rights. Certainly, there are those who advocate the use of private contracts as vehicles for altering legal rules in this area.

Certainly, another factor is the role played by plaintiffs’ counsel who serve as spokespeople, almost by default, for the interest of patients. It is generally assumed, for example, that plaintiffs’ attorneys are “suspicious of arbitration and willing to fight for a chance to get to a jury.” As a result, plaintiffs are likely to challenge arbitration agreements vigorously, and such challenges would defeat a central benefit of arbitration, namely, expedited resolution on the merits.

After reviewing the potential pitfalls discussed above, it is clear why the growth of binding arbitration has largely been a non-starter in malpractice. Among those who litigate malpractice cases day to day, there is no common understanding that the current system has failed. Lacking a clear empirical basis for believing that arbitration would be better, why face the hassles of legal review to force arbitration down the throats of patients who apparently believe that arbitration is a bad idea? In reviewing the list, however, there is one important truth. Despite conventional wisdom, there is no clear understanding that arbitration is demonstrably “better” for physicians. Indeed, some of the reasons why there has not been greater use of arbitration is the suspicion that arbitration would benefit plaintiffs in a number of important ways. As a result, in looking to the future, there is no reason based upon the present record to assume that arbitration is somehow inappropriate or inherently unfair in the malpractice context. Its possible virtues should be considered unencumbered by the ill-informed claims and counterclaims made in the heat of “tort reform” battles.

III. EXPLORING THE FUTURE OF MALPRACTICE ARBITRATION

In looking towards the future, one is confronted by a number of questions about the possible role of arbitration. If one accepts a broad view of patient interests—one that focuses not just on those slight minority of patients who currently have a malpractice claim—is arbitration a

91. See id. at 1169 (discussing the highly political nature of the extended malpractice “litigation reform” debates).
92. The use of contract to modify substantive law principles applicable to malpractice claims is not inherently anti-patient; strong policy arguments can be made that various modifications are desirable. See generally Symposium, Medical Malpractice: Can the Private Sector Find Relief? LAW & CONTEMP. PROBS., Spring 1986, 1, 143-320 (Spring 1986); Carl M. Stevens, Adopting Contract Rather than Tort Law, 50 DISPUTE RES. J. 65 (1985).
94. Weller, Fixing the Tilt, supra note 84, at 1160.
good idea? As a policy matter, should its use in malpractice be tolerated or indeed encouraged? Is there anything unique about malpractice cases that make them inappropriate for arbitration? What arbitrator qualifications should be most sought after in forming panels? Will arbitrators be as willing as juries apparently are to award defendants outright victories when they perceive the case to be non-meritorious? Will they be as able or better than juries when it comes to valuing meritorious claims? Will malpractice arbitrations in fact prove to be more cost-efficient than traditional litigation? Will arbitration deal more effectively with the special challenges of using experts?

These questions cannot at this time be answered with any confidence. Nonetheless, my personal opinion is that arbitration—if well-administered—can be a particularly effective dispute-resolution method in malpractice. These opinions are based in large part on my experience in designing arbitration procedures for specific cases. Some of these experiences are discussed in the next section.

A. The Private Adjudication Center’s Experiences with Malpractice Arbitration

Working under the auspices of Duke Law School’s Private Adjudication Center, I have, during the past five years, worked closely with malpractice litigants in discussing the voluntary use of binding arbitration. Some of the discussions were largely perfunctory with one party seeking general information on what arbitration might offer. Most discussions were more elaborate, but not always fruitful. There were numerous cases in which one party was seriously interested in arbitration only to have the other side, or a co-party, refuse the offer. In nineteen cases, however, the discussions led to an agreement about the use of binding arbitration. The disputes ranged from relatively minor cases involving less than $100,000 in damages, to two multi-million-dollar disputes involving sharply contested issues of liability. Descriptions of some of these cases

95. Our work in this regard was not limited to the use of arbitration; all forms of ADR were considered. In addition to these cases, we employed mediation, non-binding arbitration, and summary jury trials in a number of other malpractice disputes. See Thomas B. Metzloff, Reconfiguring the Summary Jury Trial, 41 DUKE L.J. 806 (1992). Our limited success in setting up arbitration raises the question whether relying on non-contractual uses of arbitration is preferable to contractual provisions between patients and providers. For a number of reasons, reliance on a case-by-case approach to setting up arbitrations is inadequate in the long run. The main problem is the fact that in a voluntary system, one party may block the use of ADR regardless of how well suited the case. To obtain agreement to use ADR in even a simple malpractice case requires the consent of five different persons or entities: (1) plaintiff (or plaintiffs), (2) plaintiff’s attorney, (3) defendant, (4) defense counsel, and (5) malpractice insurer. To some extent, these persons have divergent interests that impact their views on the desirability of arbitration. Reaching agreement becomes even more difficult if the case involves multiple defendants; if different malpractice insurers are involved, a voluntary agreement on how to conduct an arbitration could be next to impossible to obtain. Even if the parties agree that arbitration is desirable, substantial negotiations may still be needed to determine the specific parameters. Spending time negotiating the alternative ground rules defeats one of the principle benefits of ADR.
are set forth in the Appendix. Primarily, these narratives are included to provide an overview of the inherent flexibility of the arbitration process; the parties in many of these cases developed unique approaches. For example, numerous approaches were developed for the selection of arbitrators. In no case were arbitrators directly selected by one party; all arbitrators were "neutral" arbitrators even though in most cases the parties had significant input into who would be selected. The number of arbitrators varied, and a number of cases were decided by two arbitrator panels.

The nature of the decision-making process was also a point for creative thinking. In one case, in an effort to overcome what one party believed was an inherent tendency for arbitrators to reach compromise awards, the agreement provided for the three arbitrators to deliberate separately and render separate awards. In two cases, the parties agreed to limit their use of adversarial experts in favor of neutral experts jointly paid for by the litigants.

The hearings were clearly far less lengthy than trials. On average, the hearings lasted one day or less; the longest was only two and a half days. Moreover, the costs associated with the process were modest because quality arbitrators were available for a fee of between $100 and $125 per hour. The parties were also charged an administration fee of about $500 per case to reflect our efforts in setting up the arbitrations and assisting the parties. This rate was subsidized by a grant from the Robert Wood Johnson Foundation.

These nineteen arbitration cases were, of course, not randomly selected, thus no empirically-based conclusions can be drawn from the results. Nonetheless, some important points may still be made in reference to some of the commonly held assumptions about arbitration discussed above.

Included in the nineteen cases were seven cases in which liability was at issue. In six of the cases, the defendant prevailed; in only one of the cases did the plaintiff clearly prevail.96 Does this indicate that arbitration is somehow biased against plaintiffs? In fact, this rate of plaintiff victory on contested liability case is about the same as the plaintiff success rate in jury trial cases. Moreover, one must also consider the possibility of a selection bias. Some of the cases in this group appeared to be relatively weak cases where the plaintiffs' attorneys were willing to submit to arbitration rather than undergo the greater expense associated with a trial. My own interpretation of the results in these cases is that it demonstrates that an arbitration process employing neutral arbitrators can indeed make decisions on the merits and thereby avoid the "compromise" mentality that has led some to eschew the arbitration process.97

96. In one of these six cases, the liability issue was submitted to three arbitrators who returned separate decisions without deliberating. One of the three arbitrators returned an award finding liability and entered a small award for damages, but the other two found no liability.

97. In most of these cases, I personally attended all or part of the arbitration hearings
The remaining twelve cases were "damages only" cases in which the parties submitted to the arbitrators only the issue of damages. All but one of these cases involved a "high/low" agreement in which the parties established maximum and minimum recoveries to minimize the risk associated with overly generous or restrictive awards.

The results in these twelve cases clearly favored plaintiffs. Of the twelve cases, seven either were close to or exceeded the "high" figure of the agreed upon "high/low" amount. The defendant clearly prevailed, defined as obtaining a result close to or below the "low" in the "high/low," in only three cases. Of these, two of the three defendant victories were in small stakes cases. As noted above, one of the concerns with arbitration is the perceived tendency of arbitrators to "split the difference." Such an effect was not noticeable in these awards. Only two of the twelve "damages only" awards were in the middle of the "high/low" award ranges. These results lend some credence to the concern expressed by some malpractice insurers that arbitration may in fact not result in lower awards; although with reasonable "high/low" agreements, "runaway" awards can be prevented.

and reviewed the relevant documents. In each case, based upon my own experience in the field of professional responsibility, my own assessments matched the decision of the arbitrators.

98. In most of these cases, the defendant did not expressly admit liability, but rather "accepted responsibility" for the injury. The fact that the issue turns only on damages does not always mean, however, that no medical issues are presented. In many of these disputes, difficult causation issues remain. Typical is the question as to whether the plaintiff's injuries are a result of negligence (which is assumed) or rather the natural consequence of the plaintiff's underlying illness.

99. As a matter of policy, the Private Adjudication Center does not inform the arbitrators of the "high/low" agreements, thus ensuring that the arbitrators cannot intentionally chose to split the difference. In some cases, the arbitrators are told of the figures, such as in cases 3 and 6 in Table 1 in which the arbitrators were required to select either the defendant's figure of the plaintiff's figure. Such "final offer" arbitration is a variation that is designed to prohibit "splitting the difference."
TABLE 1: ANALYSIS OF "DAMAGES ONLY" AWARDS

<table>
<thead>
<tr>
<th>CASE NUMBER</th>
<th>LOW</th>
<th>HIGH</th>
<th>AWARD</th>
<th>PREVAILING PARTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>300,000</td>
<td>700,000</td>
<td>608,000</td>
<td>Plaintiff</td>
</tr>
<tr>
<td>Case 2</td>
<td>30,000</td>
<td>80,000</td>
<td>59,000</td>
<td>Middle</td>
</tr>
<tr>
<td>Case 3</td>
<td>217,000</td>
<td>383,000</td>
<td>217,000</td>
<td>Defendant</td>
</tr>
<tr>
<td>Case 4</td>
<td>20,000</td>
<td>50,000</td>
<td>67,000</td>
<td>Plaintiff</td>
</tr>
<tr>
<td>Case 5</td>
<td>150,000</td>
<td>425,000</td>
<td>422,000</td>
<td>Plaintiff</td>
</tr>
<tr>
<td>Case 6</td>
<td>300,000</td>
<td>660,000</td>
<td>660,000</td>
<td>Plaintiff</td>
</tr>
<tr>
<td>Case 7</td>
<td>250,000</td>
<td>750,000</td>
<td>850,000</td>
<td>Plaintiff</td>
</tr>
<tr>
<td>Case 8</td>
<td>10,000</td>
<td>30,000</td>
<td>21,000</td>
<td>Middle</td>
</tr>
<tr>
<td>Case 9</td>
<td>NONE</td>
<td>NONE</td>
<td>5,000</td>
<td>Defendant</td>
</tr>
<tr>
<td>Case 10</td>
<td>150,000</td>
<td>300,000</td>
<td>326,000</td>
<td>Plaintiff</td>
</tr>
<tr>
<td>Case 11</td>
<td>10,000</td>
<td>50,000</td>
<td>15,000</td>
<td>Defendant</td>
</tr>
<tr>
<td>Case 12</td>
<td>670,000</td>
<td>1.65 Million</td>
<td>4.1 Million</td>
<td>Plaintiff</td>
</tr>
</tbody>
</table>

Collectively, these nineteen cases demonstrate that if administered carefully, arbitration can be an efficient process. The average duration of the arbitrations was about six hours. In the damages-only cases, most of the cases were resolved following hearings that lasted four hours or less. Even in the most complex matter, the longest arbitration was two and a half days in a case in which the parties estimated that trial of the matter would have been a minimum of three weeks. Decisions in the cases were reached promptly, usually within two or three days of the arbitration hearing. No appeals were filed on any of the decisions; payments were usually made within a week of the receipt of the award.

Based in part upon my experiences in administering these arbitrations, what sorts of characteristics should malpractice arbitrations feature in the future?

B. The Attributes of Effective Arbitration

It is commonly argued that the key to effective protection of patient interest is the inclusion of various "consumer protection" provisions within arbitration clauses. Such clauses would require clear notice to patients about what rights they are waiving or would insist that arbitration clauses not be a condition of medical treatment or that they be revocable. In my view, such standard consumer protection add-ons are counterproductive. To the extent that they increase the transaction costs associated with entering into valid arbitration agreements, they primarily serve to deny the potential benefits associated with arbitration. More importantly, as one looks toward the future, the likely growth area of arbitra-
tion relates to managed care providers who would agree up front with all patients within the organization to a set dispute resolution system. The key is not to significantly encumber the initial decision to employ arbitration, but rather to think more seriously about what elements will maximize the fairness and quality of the arbitration process.

If consumer protection measures of the type previously used are not appropriate, what should be done to ensure the quality of the arbitration program? As I have argued elsewhere with my colleague Clark Havighurst, the key is in providing statutory safeguards to ensure the quality and neutrality of the arbitration procedure itself.\textsuperscript{100} On this point, the most important factors are the neutrality and qualifications of the arbitrator. Also important is requiring that malpractice arbitrations be administered by a neutral entity that possesses appropriate expertise. Ideally, an ADR provider handling a complex matter such as the typical medical malpractice case should, at a minimum: (1) have demonstrated expertise in administering ADR procedures, (2) employ methods of selecting arbitrators that insure the neutrality and competence of the arbitrators, (3) disclose its funding sources, and (4) develop a set of appropriate procedures. Legislation to ensure such attributes (as opposed to limiting the use of arbitration) would be welcome as the type of “second generation reforms” needed to improve the situation.\textsuperscript{101}

What else should arbitration provide that would make it better suited to the malpractice context? Flexibility in administering malpractice arbitrations is a virtue. As illustrated by the descriptions of arbitrations described in the Appendix, there is no one ideal length or approach. Rather, some degree of individualized design is appropriate for most malpractice disputes. Moreover, flexibility should also be encouraged to permit the parties to employ other ADR methods (perhaps most notably mediation) in appropriate cases.\textsuperscript{102}

CONCLUSION

Having researched both the litigation and arbitration processes in the malpractice context, I have become convinced that well designed and ad-

\textsuperscript{100} Clark C. Havighurst & Thomas B. Metzloff, S. 1232—A Late Entry in the Race for Malpractice Reform, LAW & CONTEMP. PROBS, Spring 1991, 179, 179-92.


\textsuperscript{102} The AMA has suggested in conjunction with its proposal of an administrative alternative that the dispute resolution process would be better served if decision-makers (such as arbitrators) were required to write detailed decisions. Currently, the norm in arbitration is to make a simple award without explanation of the reasoning process.

Would an arbitration requirement of a written opinion improve the situation? The benefits of a mandatory opinion requirement are likely to be minimal. Malpractice cases tend to be fact-specific; even an extensive written decision may be only marginally applicable to another case involving even the same medical specialty. To be sure, a written decision would permit more meaningful appellate review on the merits of the liability issue, but a principal virtue of arbitration is the limited nature of such review.
ministered arbitration systems would provide several advantages over traditional litigation. The primary benefits include quality of the decision-maker and speed of resolution, with its attendant potential reduction in litigation expenses. In expressing this preference, it is important to point out that the potential benefits accrue both to physicians and to claimants who currently are often unable to access the system because of its exceptionally high administrative costs. A flexible arbitration program employing use of other ADR methods in appropriate cases, qualified decision-makers, and perhaps neutral experts would be as likely—and indeed in my view more likely—to generate reliable and consistent results at a significantly lower cost than the current system.
APPENDIX

MALPRACTICE ARBITRATION CASES

CASE 1: Plaintiff presented to the emergency room late in the evening. The emergency room physician evaluated him and determined that he should be admitted for observation. Plaintiff suffered a heart attack the following morning prior to being seen by the cardiologist and prior to being treated for his condition. Plaintiff sued the emergency room doctor, the hospital, and the cardiologist. In addition to liability, the extent of plaintiff's injuries, as well as their causes, was disputed. The case had a lengthy run in the court system prior to the parties agreeing to arbitration, including an aborted trial and an appeal. During the pendency of the suit, plaintiff settled with the emergency room physician, who was arguably the most culpable defendant. Trial against the remaining defendants would have been lengthy. The parties agreed to a one-day arbitration using a single arbitrator. The arbitrator had been a superior court judge in the past. Strict limits were placed on the time of the evidence (approximately three hours per side), along with disclosure requirements to insure that each side was informed as to what witnesses and what testimony would be included. Plaintiff agreed to a cap on damages if liability were found. Following a six-hour arbitration, the arbitrator held in favor of the defendant finding that plaintiff had not proven negligence.

CASE 2: Plaintiff was a young woman with a history of back and leg pain. She was referred by her family doctor to an orthopedic surgeon (defendant) for evaluation. Defendant saw her on three occasions and ordered a series of diagnostic tests. All tests were negative. A year following the tests, she was diagnosed as having cancer behind her right knee. Her leg was amputated, but the cancer had spread to her lung requiring extensive chemotherapy and subsequent surgeries. Plaintiff was anxious to resolve the issue before she died from the cancer. The insurer did not believe there was any liability, but the potential damages were great. Plaintiff's attorney thought that they faced an uphill battle before a jury in the county in which the case was filed. Both sides were interested in minimizing litigation expenses. The parties agreed on arbitration using a three arbitrator panel. The panel would assess both liability, and if necessary, damages. Each arbitrator would render a separate decision without deliberating with the other arbitrators. Following a two-day hearing, two arbitrators found for the defendant. The third arbitrator found negligence, but made only a modest award in light of the lack of proof that earlier detection of the cancer would have changed the outcome. As a result, under the terms of the parties’ agreement, plaintiff received only a small award owing to the averaging mechanism.

CASE 3: Plaintiff, a minor child, was born with a heart problem and was transferred to the defendant hospital. Owing to hospital error, he was given an excessive dose of a drug. The error was recognized only after a number of excessive doses had been given. As a result, plaintiff suffered
two episodes of heart failure and related seizures. An MRI indicated the presence of brain lesions. As the child became older, a series of developmental delays or deficits were noted. The child had required special educational programs and other assistance. His problems were perhaps exacerbated by his parents' divorce. The case presented a situation of clear liability, but the issues of causation and damages were sharply contested. There was a conflict in expert testimony relating to whether he was suffering from developmental delays or whether the problems would prove to be serious long-term concerns. The parties agreed on a two-day arbitration using a three arbitrator panel comprised of three attorneys, one of whom had prior judicial experience. The parents desired the arbitration in part because they did not want the child to sit through a lengthy trial having to listen to experts discuss the nature of his disabilities. The parties agreed that the child need not be present during the arbitration hearing and that no transcript would be made. The parties entered into a "high/low" agreement. The resulting award was marginally above the high end of the award amount.

CASE 4: During a bunionectomy, the plaintiff was placed under anesthesia. Prior to the surgery, the saw used to cut the bone required sterilization. For some reason, the hot saw was placed on plaintiff's knee resulting in third degree burns. The surgeon believed that the accident was the nurse's fault; the nurse blamed the doctor. The insurers recognized that the case presented a swearing match between the doctor and the nurse with no way to prove either story. The parties disagreed on damages; settlement offers were about $50,000 apart when the parties decided to consider arbitration. All parties recognized that plaintiff was entitled to compensation, although there was a disagreement as between the hospital and the doctor as to which party was responsible. Litigating that issue would have been potentially expensive. Both insurers wanted an inexpensive and quick determination of the amount of damages, but wanted the process to be fair in order to avoid paying more than the case was worth. Another issue arose as to what future medical treatment the plaintiff would require. Plaintiff claimed that she was likely to undergo additional plastic surgery in order to reduce the size of the burned area. Defendant questioned whether in fact this procedure—which would cost approximately $8-10,000—was worthwhile. Both sides had experts dealing with the desirability and advisability of this subsequent surgery. The parties agreed on a "damages-only" arbitration involving three neutral arbitrators. The arbitration focused only on damages, and no evidence would be presented on the relative responsibility as between the doctor and the nurse. The parties also entered into a high/low agreement. Following a four hour arbitration, the arbitration panel awarded damages near the mid-point of the high/low range.

CASE 5: Plaintiff's father was diagnosed with active tuberculosis. As a result, plaintiff was treated by the county physician who was paid as part of a state-wide TB treatment program. An initial X-ray was read by the radiologist as indicating no problems. The department of health physi-
cian also reviewed the X-ray and agreed. A second X-ray was read by the radiologist as indicating "no change" although there were perhaps indications of a slight shadow. The department of health physician reviewed the X-ray and thought that it was worth following up with another X-ray in six months. Subsequent X-rays revealed lung cancer that ultimately resulted in the plaintiff's death. Suit was filed against three defendants—the radiologist and two department of health physicians. The case was settled early with one of the physicians who had only limited insurance coverage. The primary case was against the radiologist. Plaintiff's counsel desired to simplify the case; he agreed to arbitrate against the health department physician and then concentrate the claim against the radiologist. The key issue was liability. Here, the Department of Health physician had reviewed two X-rays. The question was whether a physician who was involved with a TB program should have noted the shadows that in retrospect represented a cancerous lesion. This case also involved what reliance that physician could put on the radiologist's interpretation. The parties agreed on a four-and-a-half hour arbitration before a two arbitrator panel. The issues were limited to the questions of liability and causation; no information was presented on damages. The parties had agreed in advance that if the panel were to find either no liability or no causation, then plaintiff would receive no compensation. If the panel found both liability and causation, then the parties had agreed upon the amount to be paid (approximately $100,000). If the arbitrators were split, plaintiff would receive one half of the full amount. Following a half-day arbitration in which experts for both sides testified following a brief factual summary presented by the attorneys, the panel ruled in favor of the defendant.