

1994

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Recommended Citation

Catherine S. Meschievitz *Efficacious or Precocious? Comments on the Processing and Resolution of Medical Malpractice Claims in the United States*, 3 *Annals Health L.* 123 (1994).

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Efficacious or Precarious? Comments on the Processing and Resolution of Medical Malpractice Claims in the United States*

Catherine S. Meschievitz**

Few issues facing the American public and policymakers today are as emotionally charged or factually disputed as discussions of the current system available for the processing and resolution of medical malpractice claims. Repeated medical malpractice “crises,” first in the mid 1970s when the issue was malpractice insurance *availability* and again in the mid 1980s when the issue was malpractice insurance *affordability*, led to recurring calls for reform of the complex system of medical malpractice claims processing and litigation in the United States. Pressure from lobbyist groups encouraged most state legislatures to enact reforms affecting malpractice insurance; liability, payments, and awards; access to the judicial system; and claims processing and resolution. Review of these reforms has consumed much attention from those involved in the system and from scholars interested in tort reform, dispute processing, and the economics of health care and tort law. Wide differences in the schemes available for claims processing exist between states. These differences, along with varying practices in health care delivery and coverage, make it difficult to generalize about “the” medical malpractice claiming and resolution system in the United States. No overt crisis in medical malpractice exists at the present time, and yet rhetoric and emotions remain strong in debates about these issues.¹ With the likely prospect of major changes in the delivery and funding of health care looming

* This article is based upon Dean Meschievitz’s speech delivered at the Fourth Annual Comparative Health Law Conference, “Medical Malpractice: A Comparative Analysis,” sponsored by Loyola University Chicago School of Law Institute for Health Law in October of 1993.

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1. See, e.g., Michael J. Saks, *Malpractice Roulette*, N. Y. TIMES, July 3, 1993, § 1, at 19; *Unsatisfied Families Want Access to Malpractice Data*, THE CAPITAL TIMES (MADISON), June 29, 1993, at 2C; *When Should a Doctor Pay for a Mistake?* PARADE MAGAZINE, Sept. 12, 1993, at 18; *Clinton Stirs Unease on Medical Malpractice*, N. Y.

before us, it is appropriate to look once again at how medical malpractice claims are processed and resolved in the United States, and assess how that system is working for the majority of the American public.

I. MEDICAL MALPRACTICE AS A "META-FIELD" IN AMERICAN SOCIETY

In determining whether the present "medical malpractice system" (used here to refer to the claiming and processing of medical malpractice claims, including formal litigation) is efficacious, asking "does it work?" is not enough, for it is a multi-institutional system of overlapping interests and activities. Consider the sheer complexity of a system that involves many different types of health care providers, health care facilities, consumers/patients and their families, insurers for both consumers and health care providers, lawyers for plaintiffs, lawyers for many types of defendants, medical and legal professional associations and advocacy groups, judicial system administrators, and law theorists. The system is truly a complex combination of individuals, interests, and legal, medical, and economic institutions dealing on a daily basis with issues affecting health, safety, corporate and personal finance, individual well being, professional careers, and public institutions.

The medical malpractice system and its constituent parts can usefully be seen as a large "meta-field"² linking well-developed systems of health care and insurance with well-developed systems of law and consumer protection. People with differing interests occupy the "meta-field" of medical malpractice and struggle for stakes in the system—stakes that are economic, political, social, cultural, and even symbolic. These struggles provide the system with a dynamic that helps maintain it as a system; continual debates and discussions of reform invigorate the field, but until recently have not seriously challenged its es-

TIMES, Sept. 24, 1993, at B11; *Philadelphia Doctors to be Offered Data on Patients Who Have Sued*, N. Y. TIMES, Aug. 27, 1993, at B7.

2. The term "meta-field" is a loose interpretation of Pierre Bourdieu's notion of the "juridical field," or "social field." Pierre Bourdieu, *The Force of Law: Toward A Sociology of the Legal Field*, 38 HASTINGS L.J. 805 (1987). A field can be seen as an area 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. See DAVID TRUBEK ET AL., GLOBAL RESTRUCTURING AND THE LAW: THE INSTITUTIONALIZATION OF LEGAL FIELDS AND THE CREATION OF TRANSNATIONAL ARENAS (Global Studies Research Program Working Paper Series on the Political Economy of Legal Change, No. 1, Madison, Wisc., 1993).

sential nature. The social and legal culture of the medical malpractice system finds most people retaining a strong allegiance to its core: the concept of liability that assigns individual blame and fault to those who have erred in the delivery of health care and assesses damages to compensate those injured by negligent behavior. Most reformers remain content to tinker with aspects of the system without challenging its central place in the legal liability process.³

It is important to underscore that within such a system efficacy will be a relative concept. The system treats its participants differently, and therefore the determination of whether it is efficacious will differ from group to group. In this article efficacy is understood to mean the ability of the system (and the law) to meet the needs of ordinary citizens. These needs include adequate access to information and assistance that can help determine the existence of malpractice, timely processing of a legal claim, and adequate compensation. To assess the system's efficacy, we must review the process and its products.⁴

This article reviews recent empirical studies of medical malpractice to obtain information on the incidence of medical maloccurrences and negligent care, patterns in medical malpractice claiming, and the use of alternative dispute resolution (ADR) processes in medical malpractice cases. Special attention is drawn to the recent Wisconsin state experiment mandating mediation for medical malpractice claims, an experiment that has not been a success. The article concludes that there is little efficacy in the current malpractice system, and that various ADR mechanisms adopted for faster and more equitable settle-

3. The social and legal culture of medical malpractice might be considered the "habitus" of the "meta-field." "Habitus" can be seen as the shared beliefs that create the structure underlying participation in the field; disputes and debates within the field do not in and of themselves challenge the legitimacy of the field. See Bourdieu, *supra* note 2. This may be changing, however, as the practice of medicine and the delivery of health care change, and as renewed proposals for no-fault processes emerge in the 1990s. These changes suggest significant breaks with the past and challenge the structure of medical care and the liability nature of medical malpractice as we know it.

4. Recent writings that have provided useful insights on how to approach the study of medical malpractice claiming and claim processing and to evaluate program quality and efficacy include John P. Esser, *Evaluations of Dispute Processing: We Do Not Know What We Think and We Do Not Think What We Know*, 66 DENV. U. L. REV. 499 (1988-89); Tom R. Tyler, *The Quality of Dispute Resolution Processes and Outcomes: Measurement Problems and Possibilities*, 66 DENV. U. L. REV. 419 (1988-89); and Peter C. Carstensen, *Two Causes for the Predictable Failure of Contemporary Tort "Reform": Naïve Analysis and Ignorance of Institutional Interaction*, 1987 DET. C.L. REV. 975 (1987).

ment of claims have either been unsuccessful or insufficient information is available on their value. The legal culture of the medical malpractice "meta-field" and the equally strong culture of the formal legal system have blocked fundamental change and reform of the medical malpractice system. Only recently, in the face of new structural and economic challenges, is there some willingness to consider radical reforms and a real restructuring of the medical malpractice system. It remains to be seen what will emerge and if these reforms will bring more efficacy to system participants.

II. RECENT RESEARCH ON MEDICAL MALPRACTICE

Students of medical malpractice claiming are fortunate to have several recent studies providing information on the system that exists today in the United States.⁵ This article will look at two categories of information: 1) medical error, negligence, claiming, and compensation, and 2) dispute resolution processes for medical malpractice claims.

A. *Medical Error, Negligence, Claiming, and Compensation*

Medical error is an inherent part of the practice of medicine and the delivery of health care; at the same time not all medical error is medical negligence.⁶ Of those harmed, whether by negligence or not, very few bring claims against their health care providers. Less than half of the few who do bring claims ever receive compensation, and an even smaller number receive actual awards pursuant to a jury trial. When people do win at trial, most do not receive enough money to compensate them for their real economic losses. At the same time some successful claimants receive sums in excess of their economic losses, and

5. Much of the following discussion draws generally upon research and research summaries such as the HARVARD MEDICAL PRACTICE STUDY GROUP, PATIENTS, DOCTORS AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION IN NEW YORK (1990); REPORTERS' STUDY, THE AMERICAN LAW INSTITUTE, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY (1991); PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL (1991); Stephen D. Sugarman, *Doctor No*, 58 U. CHI. L. REV. 1499 (1991) (book review); Thomas Metzloff, *Understanding the Malpractice Wars*, 106 HARV. L. REV. 1169 (1993) (book review); and FRANK SLOAN ET AL., SUING FOR MEDICAL MALPRACTICE (1993) [hereinafter "SLOAN STUDY"].

6. Negligence is the failure to use such care as a reasonably prudent and careful person would use under similar circumstances. Medical negligence is the failure to provide the applicable standard of care recognized for a provider's medical and social community.

some even win awards where no medical malpractice can in fact be ascertained (for example, the doctor settles early to avoid litigation or the jury makes an award based on passion rather than merit). Information obtained from three studies highlights some of these points in more detail.

The large "Harvard Study" of persons hospitalized in the state of New York over the course of several years revealed that hospital patients had a four percent risk of suffering an "adverse event" (defined as an occupance that prolongs a hospital stay by a day or more or causes death) and a one percent risk of being the victim of medical malpractice.⁷ Only 125 legal claims were ever raised by these 100,000 patients and the 1,000 injured by medical malpractice; of the 125 only 60 received any kind of payment or compensation for their claim. Of the 60 who received some award, 20 received a payment before a formal suit was filed, 35 settled prior to trial, and 5 won at trial. Independent physician assessment of the 125 legal claims suggested that malpractice did not occur in two thirds of the cases, and that of those receiving compensation approximately 30 percent received compensation where medical malpractice was not present.⁸ This study indicates that on a national level, the current system could result in an enormous "compensation shortfall" for victims of actual malpractice and a windfall for many who bring claims successfully in situations of an adverse event where negligence is not a factor.

A recent observational study in a Chicago hospital adds to our knowledge of rates of medical error.⁹ Conducted by research scholars associated with the American Bar Foundation (ABF), this study looked at rates of errors in hospital care in order to gain an understanding of the social construction of error and the transformation of medical error into disputes. The study revealed that forty-four percent of the patients in two different units of the hospital that were studied experienced at least one error during their stay, and that nearly twenty percent

7. See WEILER, *supra* note 5, at 1-16; Sugarman, *supra* note 5, at 1500-1502. In medical malpractice litigation, in order to recover for negligent malpractice, the plaintiff must establish that 1) the physician had a duty to provide care, 2) the applicable standard of care and how it was not met, 3) an injury that requires compensation, and 4) a causal connection between the injury and the negligent care.

8. Sugarman, *supra* note 5, at 1501.

9. Lori B. Andrews, Medical Error and Patient Claiming in a Hospital Setting, Paper Prepared for the Law and Society Association Annual Meeting, in Chicago, IL. (May 30, 1993) (on file with the *Annals of Health Law*).

of the patients experienced multiple (two to five) errors. In fourteen percent of the cases where errors occurred, the error caused serious injury (defined as a temporary disability, a permanent disability, or death).¹⁰ The ABF study reveals a higher rate of medical error than the New York study; this is not surprising, however, because the New York study relied on written patient records where error was recorded, whereas the ABF study reported error that was observed on hospital wards. The ABF study also found that errors went beyond what we traditionally understand to take place in classic doctor/patient treatment situations. Nearly one third of the errors involved communication failures, mistakes in the care provided by non-physician health care professionals, hospital equipment failures, and other "administrative" failings. The study observed that when the errors were first identified, little discussion took place about the errors beyond the ward; also, no efforts were made to channel information about the errors to those who might design plans to prevent future errors. Only twenty-four percent of the observed errors led to written reports of the occurrences.¹¹

This study also showed that patient claiming for an adverse event or error after the patient left the hospital was low. Only one percent of the total number of hospitalized persons in the study brought a claim. Of the small number of persons seriously harmed by medical error (many of whom were not identified in the study by direct observation), few complained beyond their hospital stay and only three percent brought legal claims.¹² The study concludes that victims of medical malpractice rarely bring claims when they might have been able to prove liability, and that hospitals, while good at first identifying when an error has occurred, are less inclined or equipped to take steps to correct the errors and/or prevent them from occurring in the future. The study recommends reforms that increase provider incen-

10. *Id.* at 6-7. Error was defined as:

incidents in which a health care provider or other hospital employee was said to have undertaken an action (or failed to undertake an action) when, at the time, an alternative more appropriate action was possible. The definition of errors did not include bad outcomes caused by the patient's condition or by an acceptable risk inherent in a particular procedure. For a subset of incidents which met [the] definition of error, the incident at issue was specifically characterized as an error by one or more of the health care workers discussing it.

Id. at 3-4.

11. *Id.* at 10.

12. *Id.* at 12.

tives to monitor, record, and reduce error, and that decrease the incidence of actual medical malpractice.

This somewhat dismal tale of high error and negligence and low claiming by victims of medical malpractice is augmented by a large empirical study of medical malpractice claiming by scholars associated with Vanderbilt University, the "Sloan Study".¹³ A comprehensive review of injuries and claims arising from obstetrical and emergency room care between 1989 and 1990 in Florida, the study involved a survey of claimants, interviews with claimants whose cases were closed, closed claims files as reported to the Florida Department of Insurance, county court records, and jury verdict reports. The researchers, limiting themselves to medical cases already manifested as claims, 1) found that most claims were for injuries that were serious, 2) that a prior relationship and better communication between health care providers and patients led to potentially valid claims being dropped, and 3) that nearly one third of the claimants had been convinced to pursue their claims by someone outside of their immediate family.¹⁴ The researchers found a higher rate of "lawyer shopping" than normally expected in medical malpractice cases; but in spite of this, only approximately one fourth of the claimants were represented by firms or individuals specializing in medical malpractice litigation. Independent physician panels assessing the validity of the claims determined that out of 127 birth-related injuries, 22 could be attributed to medical negligence, 28 did not involve negligence, and in 77 cases negligence or lack thereof could not be ascertained. Similarly, physician panels looking at emergency room cases determined that out of a total of 60 emergency room cases, 32 were attributable to medical negligence, 18 did not involve negligence, and in 10 instances negligence or lack thereof could not be ascertained. When looking at compensation the study found that there was a shortfall in awards relative to the cost of injuries: most claimants only recovered forty-four percent of their economic losses through the litigation process. The study also found that punitive damages were rarely awarded, that only a small portion of claimants received jury awards above their actual economic losses, and that larger economic losses tend to be

13. SLOAN, *supra* note 5.

14. *Id.*, at 48, 51, 64; See also Marlynn L. May & Dennis B. Stengel, *Who Sues Their Doctors? How Patients Handle Medical Grievances*, 24 L. & SOC'Y REV. 105 (1990).

undercompensated.¹⁵

This brief portrait of the medical malpractice “meta-field” suggests that from the point of view of the consumer—the patient—the present system of providing compensation for medical injuries due to malpractice is hardly equitable. Thus, one might reasonably conclude that from the point of view of the medical claimant the system is less than efficacious. One commentator sums up the situation as follows:

[F]rom the viewpoint of compensating victims, whether we focus only on victims of malpractice or on all victims of adverse events from medical treatment, . . . the current system is a disaster and a disgrace. The few are lucky lottery winners, so to speak, only about half of whom should even have been given lottery tickets. The many are ignored. Although it may not be fair to say that “*only* the lawyers win,” it can hardly be said that, from the compensation perspective, patients as a class win.¹⁶

Yet another commentator concludes that “[a]s an injury compensation mechanism, the tort system thus approaches non-existence.”¹⁷

Evidence suggests that the medical malpractice system does not appropriately compensate negligently injured patients. The next issue is whether the present system processes claims in an effective manner.

B. Dispute Resolution Processes for Medical Malpractice Claims

The traditional litigation process for medical malpractice claims has been defended by trial lawyers and consumer groups as an inherent right under our due process system; the same groups resist persistent efforts by physicians and others to alter the individual’s traditional access to the courts for redress under the law. Some argue that physicians should not be singled out and treated with preferential protections through such procedural mechanisms as shortened statutes of limitation, limits on recovery amounts, mandatory stages of evidentiary disclosure and hearings before additional tribunals (such as screening panels), and other requirements that appear to be obstacles for plaintiffs seeking access to the justice system. In turn, critics of

15. SLOAN, *supra* note 5, at 75-76, 100-107, 111-113, 123-147.

16. Sugarman, *supra* note 5, at 1504.

17. Saks, *supra* note 1.

the legal system as it relates to medical malpractice abhor the documented rise in claims against health care providers, the ease with which a frivolous or false claim can be brought, the tremendous amount of time needed to resolve disputes once in the legal system, and the expense needed to defend against claims. Cries of an overly litigious society and a population with a high propensity to sue for little or no reason, aided and abetted by greedy lawyers, have become common in recent years. Legal scholars have tried to expose the rhetoric for what it is with careful studies revealing the myths of the litigation explosion, the high number of claims and disputes that go unclaimed or unvoiced, and the small actual number of cases that proceed to final disposition in the state and federal legal systems.¹⁸

The truth, of course, lies somewhere in the middle. A general portrait of the processing of medical malpractice claims comports with that of most civil cases: most incidents never go beyond the privacy of the patient's hospital room or family—most people simply bear the burden. In theory, many more people could make claims for negligent harm than do. Of those who do bring claims the vast majority abandon their claims on the way to the court house or settle prior to trial. We have seen that few plaintiffs win at trial, and when they do they typically most receive modest awards that rarely cover the actual economic losses they incurred. Given the contingency fee system at work in tort law, claimants with small-value cases often have a difficult time getting lawyers to represent them; determining causation and liability can be complex and even somewhat indeterminate, leading to high litigation costs. Claimants tend to be what Marc Galanter has called “one-shot players,” while physicians and especially their insurers are “repeat players,” able to retain experienced attorneys specializing in medical cases.¹⁹ Most claimants do not employ medical malpractice litigation specialists, instead hiring the first lawyer they meet or the first who is recommended to them by family and friends. The

18. See Marc S. 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 S. Galanter, *The Radiating Effects of Courts*, in EMPIRICAL THEORIES ABOUT COURTS 117 (Keith O. Boyum & Lynn Mather eds, 1983); Marc S. Galanter, *The Emergence of the Judge as a Mediator in Civil Cases*, 69 JUDICATURE 257 (1986); Marc S. Galanter, *The Day After the Litigation Explosion*, 46 MD. L. REV. 3 (1986); Robert H. Mnookin & Lewis Kornhauser, *Bargaining in the Shadow of the Law: The Case of Divorce*, 88 YALE L. J. 950 (1979).

19. Marc S. Galanter, *Why the Haves Come Out Ahead: Speculations on the Limits of Legal Change*, 9 L. & SOC'Y REV. 95, 97 (1974).

Florida study revealed that plaintiffs were greatly dissatisfied with their attorneys as well as their physicians, suggesting that the entire process is confusing, inadequately explained, and frustrating to all of the parties involved.²⁰

Given this confusion as well as the actual difficulties associated with medical malpractice litigation, it is not surprising that many states have experimented with alternative dispute resolution (ADR) to create new ways of handling these cases. The benefits of using ADR methods in medical malpractice claims lie in its potential to 1) introduce into the system a more qualified decision maker for the complicated issues involved in determining liability, 2) reduce the cost of resolving the dispute, either by shortening the period of time or lowering the costs associated with the process, 3) decrease the mental anguish of going to court and being in conflict with one's doctor or patient, 4) improve the quality of expert witnesses, 5) provide new forums for small-value cases, and/or 6) reduce or eliminate the prevalence of weak or false claims.²¹ Most ADR innovations do not replace but supplement the normal bargaining and settlement structure operating within state court systems. In the traditional system, 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.²² Theoretically, well designed alternatives, providing a variety of procedures, legal strategies, and remedies, should expand the options available to both sides.

Popular ADR efforts adopted in recent state experiments or suggested anew for medical malpractice claims have included pretrial screening panels; arbitration, court ordered arbitration, or early neutral evaluation; and various forms of voluntary and mandatory mediation. It is important to assess the success of ADR methods in providing better access, more appropriate judgments and compensation, and justice to the medical malpractice system.

Pretrial screening panels, which emerged in reaction to the medical insurance availability crisis in the mid 1970s, take a vari-

20. SLOAN, *supra* note 5, at 184.

21. See Thomas B. Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 ALASKA L. REV. 429 (1992).

22. Galanter, *supra* note 19; Richard E. Miller & Austin Sarat, *Grievances, Claims and Disputes: Assessing the Adversary Culture*, 15 L. & Soc'y REV. 525 (1981).

ety of forms. Panel systems typically require claimants, prior to proceeding to the court process, to appear before a formal panel of medical and legal experts to review the evidence surrounding the medical harm. The panel determines whether the defendant is liable, and in some cases the panel may recommend the amount of compensation the claimant should receive. Panel decisions are typically not binding without the prior consent of both parties. Either party can insist on a full jury trial, regardless of the panel process. In some states a panel decision can be admitted as evidence in any subsequent trial, while in other states the panel members can be called to testify at trial.

The panel process is thought to encourage settlement of valid claims exposed during the process or to encourage the dropping of weak or frivolous claims. Empirical evidence (and public opinion) is mixed on the success or failure of the panel process. Most critics see it as a burdensome additional step for both sides before they can get to the real decision level, the trial; others feel screening panels may encourage more plaintiffs with weak claims to come forward. Supporters of the panel process argue that the process weeds out some weak claims and identifies legal issues and meritorious claims earlier.²³

Private arbitration allows parties to voluntarily enter into a process where the parties select a neutral arbitrator (to replace the judge or jury), and the arbitrator decides the merits of a claim. The decision is binding. Arbitration can start at any stage in the dispute process, depending on the nature of the agreement to arbitrate. Many different areas of law utilize arbitration, and it is a well-known and reliable method of resolving labor and securities conflicts. Fourteen states enacted legislation allowing for medical malpractice arbitration in the early 1970s. However, empirical evidence is limited on how it works, in large part because few claimants seem to elect arbitration. Obstacles to its use appear to include party preferences (on both sides) for the jury to determine factual disputes, a perception that arbitrators will always compromise in order to reach a decision whether it meets the needs of the parties or not, and the

23. See Jonathan S. Aronie, Note, *Alaska's Medical Malpractice Expert Advisory Panel: Assessing the Prognosis*, 9 ALASKA L. REV. 401 (1992) (noting that Alaska's panels consist of three health care experts, making it a body of trained, neutral court-appointed experts); Jona Goldschmidt, *Where Have All the Panels Gone? A History of the Arizona Medical Liability Review Panel*, 23 ARIZ. ST. L.J. 1013 (1992); Jean A. Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. WASH. L. REV. 181 (1990).

fear on the part of insurers that a rapid claims resolution process will cause the number of claims asserted to increase.²⁴

Court ordered arbitration is a new process employed by several states for civil cases in general. There is little evidence of its effect on medical malpractice cases per se, but some empirical studies have shown that claimants are generally pleased with the process and that it does seem to expedite claims resolution.²⁵

Similarly, early neutral evaluation is a court ordered preliminary evaluation process that employs an experienced, neutral attorney to assess the case based on brief, evidentiary presentations by the parties. Although early neutral evaluation has been limited to federal cases in a few states, and thus is not known to have been used for medical malpractice cases,²⁶ aspects of the process can be identified in some ADR processes (for example, the Wisconsin mediation panel process discussed below). Also, it is one of several options typically promoted by court reformers when discussing the options available to judges empowered to refer litigants to ADR processes prior to trial.

Mediation of medical malpractice claims is perhaps the most popular addition to the legal reformers' agendas, appearing as part of many of the current health care reform bills before Congress. Mediation is commonly understood to mean informal, voluntary negotiation between disputants or litigants (with or without legal counsel) aided and facilitated by a neutral mediator. The mediator helps the parties frame the issues, discuss their positions, and explore solutions to the issues at stake. Although it is used in a variety of legal areas, mediation is far less common in resolving medical malpractice claims. Florida and Wisconsin recently adopted provisions that allow trial court judges to refer civil cases, including medical malpractice cases, to mediation.²⁷

Wisconsin has experimented with alternative processing schemes for medical malpractice claims since the mid 1970s,

24. See Nicholas P. Terry, *The Technical and Conceptual Flaws of Medical Malpractice Arbitration*, 30 ST. LOUIS U. L.J. 571 (1986); Metzloff, *supra* note 21.

25. See E. ALLAN LIND, *THE PERCEPTION OF JUSTICE: TORT LITIGANTS' VIEW OF TRIAL, COURT-ANNEXED ARBITRATION AND JUDICIAL SETTLEMENT CONFERENCE* (1989); Metzloff, *supra* note 21, at 444.

26. See David I. Levine, *Northern District of California Adopts Early Neutral Evaluation to Expedite Dispute Resolution*, 72 JUDICATURE 235 (1989).

27. Metzloff, *supra* note 21, at 440-441. Wisconsin's Supreme Court has adopted a Rule effective July 1, 1994 allowing for judges to refer cases to several different types of ADR, including mediation, prior to full judicial review and processing. WIS. STAT. § 802.12 (West 1994).

adopting at first a traditional prescreening panel system from 1976 through 1986, and then, in the second wave of reform, switching from the screening panel approach to what was labeled and ostensibly intended to be a "mediative" approach to claims resolution. It is important to review the highlights of Wisconsin's flawed experiment in medical malpractice and ADR.²⁸

In a special legislative session in May of 1986, the Wisconsin legislature enacted Act 340 requiring prelitigation mediation for all medical malpractice claims.²⁹ This legislation followed a period of intense lobbying and political activity within the state and replaced a ten-year-old mandatory prescreening panel system—the Patient Compensation Panels (PCPs).³⁰

Under the new mandatory mediation panel system (MMPS), which remains in effect in Wisconsin at this time, claimants must file a request for mediation within fifteen days of filing their malpractice claims in circuit court. Claimants may also request mediation before filing their claims in court. The statute of limitations is tolled for the ninety-day mediation period and an additional thirty days following the end of the mediation period. Parties submit a statement of the claim or rebuttal to the claim and should share all patient health care records in their possession. However, conducting discovery, such as depositions of witnesses and additional compulsory production of records, is prohibited during the mediation period.³¹

The MMPS panel program is administered by the Office of the Director of State Courts (MMPS Office). The enacting statute provides little detail of how the mediation system should be run, giving the administrative office an opportunity to develop its own set of guiding principles and practices. Statutory guidelines require that the panels consist of three members: an attorney who chairs the panel, a physician or health professional with some expertise in the subject area of the claim, and a public

28. See Catherine S. Meschievitz, *Mediation and Medical Malpractice: Problems with Definition and Implementation*, 54 LAW & CONTEMP. PROBS. 195 (1991); CATHERINE S. MESCHIEVITZ, *MEDIATING MEDICAL MALPRACTICE CLAIMS IN WISCONSIN: A FINAL REPORT* (1991).

29. WIS. STAT. ANN. §§ 655.42-.68 (West Supp. 1993).

30. The PCPs took one of two forms: a formal five-member panel consisting of two attorneys, two physicians, and one lay person, or an informal three-member panel consisting of an attorney, a physician, and a lay person. The panel determined negligence and compensatory awards. The constitutionality of the panels was upheld in 1978. *State ex rel. Strykowski v. Wilkie*, 261 N.W.2d 434 (Wis. 1978).

31. WIS. STAT. ANN. § 655.58.

member appointed from a pool of individuals recommended by the governor.³² Panel members receive little or no training: only the attorney members receive three hours of instruction from a private mediator skilled in mediation training.

MMPS panels strongly resemble the old PCPs in their composition and function. At the invitation of the MMPS Office, most of the chairs of the old panels (who were attorneys) continue to serve as chairs of the new mediation panels. Many physicians now serving on the mediation panels served before as well.³³ Turnover occurs most frequently with the public members, because they are appointed by the Governor every two years. Thus, 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."³⁴

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. If an extension is granted the statute of limitations is tolled for the extension period. Parties must attend the mediation session unless excused by the MMPS Office. Most parties are accompanied by their attorneys. 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 facilitate compromise and settlement where possible, but if mediation does not produce an agreement, panel members are then free to advise the parties of their projections of the likely outcome if the case were to proceed to trial.

My study³⁵ of the MMPS in Wisconsin revealed that the panels were not settling claims, and, in fact, claims were proceeding within the trial court system in higher numbers than before. Prohibition of discovery and the lack of clear medical information at these early stages of the process precludes rapid decisions regarding causation and harm. In addition, the panels

32. WIS. STAT. ANN. § 655.465(2).

33. 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.

34. All members receive \$150 per panel attended as well as minimal reimbursements for travel and meals.

35. See *supra* note 28.

did not practice mediation, but rather resembled the old panel process as a quasi-hearing and claim evaluation process. Attorneys dominated the sessions and the panel process did not allow for meaningful direct exchange and negotiation between parties, as is typical of mediation. For these reasons, it is not mediation at all; at best it can be seen as an “early neutral evaluation” mentioned earlier. Finally, doctors and lawyers in the State of Wisconsin are not interested in creating a real mediatory panel process. Indeed, there is ample evidence that although no one liked the process, everyone was sufficiently satisfied or at least not harmed by the MMPS process, so that no one felt the need to alter the status quo. This could be seen as yet another example of the power of the “habitus” of the legal field resisting real reform and innovation while seeming to adapt to newer processes such as ADR.

III. ASSESSMENT AND REFORM AGENDAS— AN AFTERTHOUGHT

This review of recent research on medical malpractice compensation and claims processing, whether by the traditional litigation process or newer ADR fora, suggests that the system is not meeting its basic need to provide the ordinary citizen with adequate compensation for medical malpractice or to provide speedy, accessible processing of the claims. Selected ADR experiments in the medical malpractice arena indicate that while a spirit of experimentation prevails in many states, present ADR efforts have either failed or at best been modestly successful; most often there is far too little information on which to base firm conclusions that ADR mechanisms are appropriate—or not—for medical malpractice cases.

Interestingly, reforms and trends being discussed in medical malpractice and policy circles now suggest significant changes may occur, changes that will radically alter the basic nature of the health care system. Financing, insurance, health care delivery, and patient-provider relationships will be different for most people in the near future. This may make room for a more serious reconsideration of the medical malpractice litigation system. For example, in the future, as more health care providers become involved in managed care processes, there may be less reason to support the traditional physician standard of care and individual liability for medical negligence. Continued institutionalization of alternative dispute resolution practices (in spite

of mixed data on their success) will introduce new groups of actors and professionals into the dispute and into the legal system, thus affecting the role of lawyers in the process. For these reasons, calls for reforms such as enterprise liability and no-fault insurance for medical maloccurrences demand more attention than they have received to date from students and scholars of medical malpractice claiming. Dispute-processing phenomena must be rigorously examined and their potential efficacy in certain types of claims resolution situations must be clarified.

Laws alone cannot dictate or alter the behavior of numerous groups of people; the strength of the “meta-field” of medical malpractice is such that legislation alone will not change the system. However, some of the changes noted earlier have the potential to dramatically affect the dynamic of the “meta-field” of medical malpractice as stakes, rights, interests, and terrain shift visibly from the past. The “habitus” or culture of the medical malpractice litigation system may be facing its first real challenge to its core. Renewed suggestions to abandon the contingency fee in tort cases will also directly challenge the traditional legal culture of the plaintiffs’ bar. Keeping the analytical framework of the “meta-field” in mind may assist us as we review reform agendas and their possible affects—individually and systemically—on the field of medical care, the legal system, and the lives of ordinary citizens.