



MEDIATION IN MEDICAL NEGLIGENCE CASES

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Paper presented at a seminar on "Law and the Changing Health Care Environment," sponsored by Washington Law School Foundation, June, 1995

I. GENERAL

Mediation is a fairly simple concept. All sides to a dispute sit down with a neutral person who serves as a "facilitator" in settlement discussions. How or why mediation works in resolving disputes is less well-understood, even by those who regularly participate in the process. There are many perspectives on the mediation process and its role in helping parties to settle disputes; following are a few:

- Mediation is a condensed and more efficient negotiating process, with offers and demands being made over a period of hours rather than days or weeks.
- Mediation is a form of "day in court" for clients (especially personal injury plaintiffs) with the mediator being the authority figure to whom facts and feelings can be presented and psychological "closure" can be achieved.
- Mediation provides the psychological "fulcrum" for a settlement, since both sides come to the mediation with the pre-determined idea that they want the case to settle at that session, and they are emotionally and financially invested in the process.
- Mediation allows education of a client who is difficult to control and has unrealistic expectations. The mediator can be the "nay-sayer" rather than the attorney who is supposed to be an advocate for his/her client.

- Mediation allows the use of "trial balloons" during negotiation. Rather than losing bargaining leverage by advancing a particular dollar figure, a party can have the mediator pose a hypothetical: "if the plaintiff would take "x" dollars, would you consider paying that amount?"

- In multi-defendant cases (or those with subrogation lien holders or other stakeholders in the case), mediation allows simultaneous negotiating of all issues, with all of the players being present.

- Mediation allows communication of information about each side's case in a non-confrontative manner. The mediator can point out weaknesses or strengths of a position without forcing the adverse party to respond in a manner that creates conflict.

Mediation is all of those things, and probably can be viewed from other perspectives as well. In the conventional view, mediation doesn't "cause" a case to settle, since the parties control what happens and a settlement only occurs when both parties are satisfied with the result. Yet the mediation session offers opportunities for the settlement process that is not readily available to the parties themselves.

In the normal process of negotiating a settlement, both sides are wary about disclosing their "real" objectives so that they can preserve their bargaining position. This can result in a stale-mate situation with each side getting locked in to unrealistic dollar figures. Often one side does not know how the other side truly values the claim, and the

negotiating process is a means of learning that information. Offers and demands thus serve to communicate to the other side what amount is viewed as a realistic value.

Thus, the plaintiff who has tentatively valued a claim at \$150,000, but isn't sure how the defense evaluates the claim, may make an initial demand of \$350,000. If the defense response is an offer of \$100,000, the plaintiff will quickly adjust his/her thinking to try to achieve a settlement of \$200,000. On the other hand, a responsive offer of \$30,000 may result in the plaintiff reducing the settlement goal to \$100,000, since the low offer may indicate the defendant only has authority for that amount or strongly disagrees with the plaintiff's value. As both sides know, the value of a case is not simply a prediction of what a jury would award, discounted for factors of risk and cost. A case has a value in the market-place consisting of the "seller" (the plaintiff) and the "buyer" (the defendant). During a mediation, each side is constantly acquiring and processing information about how much the seller will take, and how much the buyer will pay, to settle a claim.

2. MEDICAL NEGLIGENCE CASES

The above considerations apply in any personal injury case, and medical negligence claims are no exception.



There are some significant differences in medical negligence cases, however, that make the mediation process somewhat different.

First, medical negligence cases are often very complex in terms of the factual and legal issues. This means there are more issues to dispute and more difficulty in evaluating how the final outcome would be affected by those issues. For the mediator, this offers more opportunities to point out the risks of going to trial, especially to the plaintiff who has to meet the burden of proof in establishing both negligence and causation.

Second, the costs involved in prosecuting and defending medical negligence cases are much greater than in most personal injury claims. This means the stakes are higher for both sides if a case does not settle, since a failed mediation will often mean both sides will incur substantial expense in going forward with litigation. The cost factor becomes a major motivator for both sides to engage in meaningful mediation.

Third, it is quite common to have multiple defendants in medical negligence cases. The classic case is one with a physician and a hospital as defendant. This creates both impediments and inducements to settle. There will be difficulty in apportioning risk and fault among the defendants, but the defendants often want to resolve their own dispute so that it does not spill over into the patient care setting. Unfortunately, with so few liability carriers it sometimes happens that past disagreements between the carriers will carry over into a particular case. What happened

in the last case that settled, or didn't settle, with the same carriers involved, may affect how a carrier looks at the next case.

Fourth, the personal feelings of both plaintiff and defendant frequently impact how a case is evaluated. The injured plaintiff often feels betrayed by the health care provider whom he/she feels caused an injury, or who failed to live up to the trust that was placed in the provider. Unlike a typical motor vehicle case, where the parties do not know each other, the plaintiff often has had a long-term relationship with the defendant, sometimes over a period of many years. If the relationship was not long-term, it may nonetheless involve a high level of trust, such as that of the patient with a surgeon. The health care provider, on the other hand, often has a strong emotional response to being sued and views the case as a challenge to his/her professional competency or reputation, as well as a betrayal of trust by a patient. The fact that all settlements, for any amount, are reported to the National Data Bank, and settlements over \$20,000 are reported to the State Disciplinary Boards, is often a major impediment to a physician consenting to a settlement.

Fifth, in many medical negligence cases the same attorneys and carriers are involved in numerous cases. There is thus more shared knowledge about the individual attorneys and their abilities, as well as about the carriers and how they value particular kinds of injuries or claims. The level of sophistication is often very high. At the same time, there is often less of a "value data-base" in the form of jury verdicts because fewer medical negligence cases go to trial. In the motor vehicle setting, there may

be scores of verdicts in cases involving rear-ender accidents or cervical strain/sprain cases. In a case involving bowel perforation during a laparoscopic cholecystectomy, however, there may be no precedent at all since no cases have been tried to a verdict.

As in all litigation, the costs of undergoing the litigation process and taking a case to trial are so great that there is a new emphasis on alternative dispute resolution in medical negligence claims. Although arbitration sometimes is utilized, mediation thus far is the preferred means of resolving a claim without the need for a trial.

The future may see variations or combinations of ADR methods. A recent example was a medical negligence wrongful death case in which the parties mediated unsuccessfully, and then used the last demand and offer as the figures for a "baseball" arbitration. Because the plaintiff and defendant physician resided in the same small community, and had known each other for many years, neither side wanted the publicity of filing a lawsuit and litigating the claim. The defendant admitted liability, but there was a genuine dispute about what the settlement amount should be.

In the "baseball" arbitration, a three-attorney panel was used (this is the common arbitration method in underinsured motorist claims), with each side selecting one arbitrator and those individuals selecting the third or "swing" arbitrator. Because the arbitrators resided in different cities, it was agreed that each side would submit informal written material to the arbitrators, and the panel would participate in a conference phone call

to reach a decision. The last offer had been \$200,000, and the last demand was \$275,000, so the arbitrators simply had to pick one of those figures as the award. During the mediation, it had been agreed that the last demand and last offer would be the figures used in the arbitration, so there had been some pressure on both sides to come up with realistic figures for settlement. Sticking to an unrealistic figure would have meant greater risk that the other side's figure would be chosen as the award in the arbitration.

There were very large savings in cost and time to the parties in using this method of resolving their dispute. It also involved less rancor and emotional distress for both the elderly widow and the physician. Ideally, the case would have resolved during mediation, but occasionally there are good-faith disputes that require a binding arbitration process to achieve a resolution.

