

# Chapter 30

## Alternative Dispute Resolution

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Mediation  
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Conclusion

Disputes are as common in health care as in other industries and social circumstances that involve differing interests. However, resolving medical disputes using the formal process of litigation is time-consuming and expensive and may not suit the parties' needs. Thus, beyond formal adjudication, other alternatives may provide better opportunities to effectuate a resolution that is acceptable to the parties.

The alternative dispute resolution (ADR) movement has recognized the limitations of formal adjudication and has employed other mechanisms through which conflicts may be resolved. ADR methods, in combination with formal adjudication, offer a broad range of tools to address the concomitantly broad array of conflicts that may arise in health care.

Generally the binding or nonbinding nature of any ADR process is based on contract. The terms of the agreement dictate whether and which specific ADR process must be followed in an effort to resolve a dispute and whether the assessment is simply advisory or is legally binding on both parties.

This chapter reviews some of the main ADR methods and indicates the types of circumstances that appear to be most beneficial for each method's use. In addition, the controversial subject of ADR application to malpractice claims is discussed. Finally, application of ADR methods to nonmalpractice, modern health care disputes is illustrated through the presentation and review of several case scenarios.

### MEDIATION

Mediation is a process by which a neutral third party assists disputing parties in negotiating a resolution. The mediator merely assists the parties; he or she has no formal power to impose any outcome on them. Usually the mediator does not evaluate the legal rights of either party and merely acts as a facilitator for communication between the parties. The parties generally select the mediator. The process usually is informal, with no set rules except those imposed by the parties or the mediator in an effort to further productive communications (e.g., no interruptions when one party is speaking).

There are two types of mediation. Traditional mediation (also known as interest-based mediation) focuses on creating a mutually acceptable solution to resolve disputes and does not involve an evaluation of the legal strengths and weaknesses of each party's case. However, in rights-based

mediation there is a focus on the legal rights of the parties, and thus the process is more akin to evaluative processes, such as early neutral evaluation.

Mediation is a voluntary process entered into by the parties in an effort to resolve their dispute. Generally, enforceability of these mediated resolutions is a function of private contract law; any agreement to mediate, as well as an agreement to abide by the mediated decision, is enforceable according to the terms of the contract.

The major advantages of mediation include the private nature of the process and the confidentiality of its results; the process focuses on improving communication between the parties so that the interests, goals, and needs of each are identified and communicated to the other. This dynamic leads to the identification of common interests and hence to a mutually acceptable resolution of the conflict for the parties. This process also gives the parties an opportunity to express emotion (in or outside the presence of the other party), shifts the focus of the conflict from past to future, allows the disclosure of interests important to the individual parties that each is reluctant to disclose to the other, and permits the parties to provide new information that may be helpful in resolving the dispute.

### Co-Mediation

Co-mediation is the use of two or more neutral mediators working together to resolve a dispute. It has been favored in the area of family dispute resolution, where two experienced mediators in different disciplines each bring their own expertise to the process. Co-mediation has also been utilized to resolve medical malpractice disputes, where lawyers from the plaintiffs' bar and the defense bar join together in assisting parties in analyzing their claims. Occasionally, co-mediation is utilized in highly complex commercial disputes.

The co-mediation model is distinguished from traditional mediation in that at least two co-mediators are used instead of a single mediator, and the co-mediators are practicing medical malpractice attorneys—one plaintiff's and one defense—who are experts in medical malpractice litigation and are also trained in mediation. Traditional mediators often are not experts in malpractice law, albeit are expert mediators.

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The attorney co-mediators are selected from an assembled panel of leading medical malpractice trial attorneys in the region. The co-mediators bring expertise from both sides of the bar in appraising the merits and valuation of malpractice cases. This adds credibility and trust among litigants during the co-mediation process.

The co-mediation process is voluntary and nonbinding, and hence less risky to the parties. This is necessary to avoid discouraging participation. The process is confidential, and what is said during mediation will not be admissible at a subsequent trial, although such information would be given up in litigation.

Presently, the number of medical malpractice cases taken to mediation is very small, close to 1%. Physicians have not warmed to traditional mediation and settlements because the payouts on behalf of physicians to plaintiffs are reportable to the National Practitioner Data Bank (NPDB). However, if all parties can be brought to the mediation table before a written demand for compensation is presented by the plaintiff's attorney to the physician defendant, a settlement payment is not reportable to the NPDB. The written demand for compensation triggers reportability. Co-mediation may remove this traditional impediment to mediation. A co-mediation program involves prior physician buy-in, combined with a system to encourage early dialogue of adverse events between physicians and patients. This approach may be more likely to produce appropriate settlement payments that are not reportable to the data bank.<sup>1</sup>

Since 1995, Rush-Presbyterian-St. Luke's Medical Center in Chicago has utilized a voluntary, nonbinding mediation program to resolve malpractice cases expeditiously and cost-effectively.<sup>2</sup> The Chicago Rush Hospital model involves simultaneous participation of practicing medical malpractice litigators from both the plaintiff's and defense sides as neutral co-mediators. Two mediators can bring different strengths, expertise, and perspectives to the process when they work effectively as a team. The approach has an impressive track record. About one-third of the malpractice suits at Rush Hospital go into the voluntary mediation program each year, of which 90% are successfully settled, producing a 50% reduction in annual defense costs and a 40% to 60% saving in payouts as compared to comparable cases that have gone to trial. The defense costs for medial malpractice cases that go to trial can average \$100,000 or more.

The Rush model can also integrate co-mediation into a health system's risk management system more programmatically than is traditionally done. In the Rush model, co-mediation lasts 2 to 4 hours, and the physicians are not present. The primary focus is on settlement numbers, which are discussed early. The co-mediators may place a monetary value on the case, and the process is evaluative. There is an option of utilizing either attorney co-mediators or retired judges. There is little focus on nonmonetary remedies, but there is a formal apology from the institution's counsel after settlement.

There are some modifications of the Rush model. Medical liability mediation alternatives are available that increase the time of co-mediation to 1 to 2 days; allow physician presence and participation, discuss ranges of

settlement numbers only after eliciting the interested parties' stories, and do not place a specific number on a case; increase the option of litigators to include co-mediators or single mediators, retired judges, or other professional mediators; discuss nonmonetary remedies in addition to monetary settlements; provide for a personal apology from the physician as well as the hospital; and emphasize the human dimension of the dispute.

In 2003–2004, Governor Edward G. Rendell announced a series of immediate and long-term proposals to address Pennsylvania's medical malpractice situation, including the creation of a statewide, defense-initiated mediation program, based on the Rush model. It would require all Pennsylvania hospitals and health systems, in addition to Mcare, to implement the co-mediation program. The critical elements of the Pennsylvania Medical Malpractice Mediation Program (PM3P) are voluntariness, defense-initiated, involves co-mediation, and mediators will be practicing plaintiff and defense medical malpractice attorneys who are certified in mediation.<sup>3</sup>

## ARBITRATION

Arbitration is a formalized system of dispute resolution in which parties provide proofs and arguments to a neutral third party who has the power to impose a binding decision on the parties. A common variation incorporates the use of multiple arbitrators (e.g., one is selected by each party and the chosen arbitrators choose a third). Arbitration is similar to formal adjudication except that the parties are allowed only limited pretrial discovery if any, the hearing is less formal, and the rules of evidence are not as rigidly applied in an arbitration proceeding.

There are four general categories of arbitration:

1. *Compulsory*. Each malpractice dispute would be submitted to arbitration.
2. *Voluntary*. Each malpractice dispute could be submitted to arbitration, but in contrast with compulsory arbitration, under this category the right to a jury trial is not lost; this applies to both the plaintiff and the defendant.
3. *Binding*. The arbitration award would be final and binding, with respect to both liability and damage determination.
4. *Nonbinding*. The arbitration award would not be final, and either the plaintiff or the defendant may elect to litigate a claim from the beginning, a situation that is costly both in time and money.

Arbitration has been mandated by law for certain conflicts, such as labor disputes, and is used voluntarily by parties to resolve private disputes. When private parties agree to use arbitration, they must address a certain number of issues to ensure that the process will be useful. For example, the parties must decide on a method for selection of the arbitrator or arbitrators; stipulate who will pay for these services; set an objective standard by which the arbitrator or arbitrators will assess the conflict and claims of the parties (e.g., the law, trade or industry customs, or some combination); and specify the procedural rules that the arbitrator or arbitrators will follow. Unless otherwise

indicated in the terms for arbitration, arbitration does not allow for pretrial discovery. Arbitration is most frequently used as a final, binding procedure.

### Advantages of Arbitration

There are several major advantages that may result from using arbitration. For example, arbitration allows the parties to draw upon arbitrators with specialized expertise relating directly to the conflict, the arbitrated decision is final, the dispute proceedings and the decision itself are private, the procedural rules are determined by the parties, and the cost for resolving the dispute is relatively low (in terms of time and money) as compared with formal adjudication. Of course, whether these advantages are realized depends on the specific conflict, the parties, and the arbitrator or arbitrators involved. There is a strong public policy in favor of arbitration, and state and federal law makes agreements to arbitrate specifically enforceable.<sup>4</sup>

### Disadvantages of Arbitration

The disadvantages of arbitration include difficulty under some state laws of obtaining binding arbitration; problems of arbitration contracts that are imposed, not negotiated minors' rights and third-party rights; adverse attitudes of judges and attorneys toward arbitration; and the risk of further expense due to preparation for two separate hearings, where a trial after arbitration is available. Additionally the constitutionality of arbitration under some state laws may be subject to question.

Unlike formal adjudication, once an arbitration decision has been made, there is no default mechanism through which the decision is enforced. However, the arbitration decision may be judicially confirmed by bringing the decision to court; failure to abide by the arbitration decision at that point constitutes contempt of court. Both the Federal Arbitration Act and the Uniform Arbitration Act give courts jurisdiction to confirm (or refuse to confirm) an arbitration decision.

### Court-Annexed Arbitration

Arbitration also may be part of an official state-sanctioned process. In these situations the government mandates that the parties go through arbitration before formal adjudication. Generally this "court-annexed arbitration" is provided by state law and may require that a certain class of cases (e.g., automobile torts) or a certain monetary amount be at issue.<sup>5</sup> Some states, however, exclude certain types of claims from arbitration, such as those involving personal injury, tort, and/or insurance contracts.<sup>6</sup>

## HYBRID METHODS

### Med-arb

"Med-arb" is a combination of mediation and arbitration. In this ADR process the parties agree to mediate their dispute first, using a neutral third party as a mediator.

If mediation does not result in an agreement or settlement, then the mediator changes roles and becomes an arbitrator with the power to issue a final and binding decision with regard to the dispute. The primary advantage of using this hybrid method is its potential efficiency: the same neutral third party is used in both mediation and arbitration so that there is no need to educate him or her regarding the facts of the dispute and interests of the parties. However, a significant disadvantage of med-arb is that the parties may not substantively participate in the mediation stage because sensitive disclosures may be used against them if and when the neutral evaluator assumes the role of an arbitrator.

An alternative to this standard med-arb is med-arb that results in only an advisory arbitration decision. This process attempts to mitigate the identified problems with med-arb involving binding arbitration. Because the mediator has no binding power to arbitrate a final decision, the parties have an increased incentive to substantively use mediation to resolve their dispute. It also serves to allow the mediator as an advisory arbitrator to merely indicate what he or she believes the ultimate result would be at arbitration. However, the clear disadvantage of this process is its potential length; an extra step of binding arbitration may be required.

### Mini-trial

The mini-trial is an evaluative process most often used for business and commercial disputes. Attorneys representing each party make summary presentations to a panel composed of a neutral advisor and high level executives from each party who have the power to accept a settlement. After the presentations, the executives try to settle the dispute through negotiation. If negotiation fails to result in a settlement, the neutral advisor provides an assessment as to what he or she considers to be the probable outcome of the dispute. Major beneficial characteristics of a mini-trial are that the process is voluntary and confidential; the parties agree to follow certain protocols or procedures; before the mini-trial, the parties agree to informally exchange important documents, provide summaries of witness testimony, and provide short statements regarding the dispute (and often provide that this information is confidential and inadmissible in any future proceeding); and a neutral third party who has expertise in the subject matter (e.g., a former judge) is chosen by consent of the parties (this neutral party may take a passive role in the process or be more active, such as taking on the role of a mediator).

### Summary Jury Trial

The summary jury trial is an evaluative process similar to a mini-trial, but it differs in several important ways. These differences stem from the goal of the process—determining what a jury might decide in the case. Hence, instead of a third-party neutral and corporate executives, a judge and an advisory jury drawn from the jury pool are used. Jurors are not told that their role is advisory until after they give

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their verdict. Attorneys for each side make summary presentations as in the mini-trial; however, the presentations usually are based on information that has been the subject of discovery and would be admissible at trial. Once the advisory jury has announced its decision, jury members answer questions regarding the verdict and their assessment and reaction to particular evidence and arguments. The attorneys and their respective executive representatives then attend a mandatory conference to discuss settlement. If no settlement occurs, the advisory jury verdict is not admissible in future final adjudication procedures.

A summary jury trial requires significant time and resources because it is similar to formal adjudication. This method is thus most useful when the dispute is unique or novel, when circumstances preclude an easy prediction of what a jury would decide, and when such unpredictability is what is preventing settlement.

## OTHER FORMS OF ALTERNATIVE DISPUTE RESOLUTION

### Early Neutral Evaluation

Early neutral evaluation is usually a court-annexed process that requires the parties to have their dispute assessed by an experienced third-party neutral evaluator on the basis of short presentations by both parties. It is thus a rights-based procedure like arbitration and formal adjudication. Usually the third-party neutral is a volunteer attorney chosen by the court. Once the presentations are made, the parties negotiate in an effort to settle the dispute. If the parties do not settle, the neutral evaluator assists them in simplifying and clarifying the case so that it will be more amenable to formal adjudication.

### Private Judging

With the advent and growth of ADR, a significant private market has emerged to render adjudicative services and decisions. Private judging (also known as *rent-a-judge*) is a reflection of this growth. Many of these participants are retired judges who provide informal adjudication or engage in other ADR processes. These private judges are paid by the parties involved and may be empowered by state statute to enter final judgments that have precedential value and are appealable to appellate courts, as are rulings made in formal adjudication.<sup>7</sup> California, Florida, and Texas have statutory provisions that require referral of certain court cases to private ADR providers paid for by the parties.<sup>8</sup>

### Screening Panels

Screening panels usually are involved in state-mandated pretrial assessments of medical malpractice cases. Plaintiffs, before submitting their medical malpractice claims for trial, are required to have their case assessed by a special panel; this panel usually is composed of physicians or other medical professionals, attorneys, and laypersons. The panel hears the plaintiff's case and may issue a nonbinding opinion. Usually, either party can bring the case to court, regardless

of the panel's assessment. Some states allow the panel's findings to be introduced as evidence in the court adjudication. Difficulties center around the administrative burdens these panels represent and the associated delays; furthermore, assessments may be made too early in the process, before discovery has been accomplished.

### Settlement Conference

In another form of ADR known as the *settlement conference* or *voluntary settlement conference*, a judge, a set of attorneys, or a "settlement master" (i.e., an independent party who assesses such conflicts) reads briefs and materials and hears presentations from both sides of a dispute, and then actively seeks to craft a settlement for the parties. As opposed to mediation, where the intermediary is merely a facilitator, in a settlement conference the intermediary is an active participant in the process. Often, after reading the submitted documents and hearing each side, the intermediary may caucus with each party independently and move between the parties in an effort to fashion a settlement. Courts use settlement conferences before formal adjudication to encourage parties to settle cases before they go to trial. Indeed, some courts will not set a case for trial unless a settlement conference has been held.

## ALTERNATIVE DISPUTE RESOLUTION AND MEDICAL MALPRACTICE CLAIMS

Although a wide variety of medical disputes are amenable to ADR methods, one type of conflict that has drawn significant attention to the use of ADR (specifically, arbitration) is the medical malpractice dispute. Those in favor of using ADR methods to resolve malpractice claims cite the associated reduction in cost, the involvement of a more informed decision-maker, the reduction in emotional trauma that results from formal adjudication, the ability for plaintiffs with "minor" injuries to have their claims heard, and the reduction in frivolous malpractice cases. State law often dictates how these contractual agreements must appear and the conditions under which they are valid,<sup>9</sup> subject to federal law.<sup>10</sup>

The difficulty with applying ADR to medical malpractice disputes is primarily twofold. First, any voluntary process requires participation by all parties and their attorneys. However, the parties may believe that a trial by jury will increase their chance of success. Defendants may be reluctant to participate because they will be reported to the National Practitioner Data Bank if any amount is paid to end the dispute. Second, malpractice cases involve complex issues of fact, and full and adequate assessment will most likely require extensive time and effort. Summary processes therefore do not easily lend themselves to malpractice disputes. Mandatory, binding arbitration could address the voluntary party and attorney participation problem, as well as provide for appropriate technical expertise; however, it too is limited by the summary nature of the assessment.

Although arbitration has its limitations, many institutional health care providers and managed care organizations (MCOs) now use mandatory arbitration in their contractual agreements with patients to resolve any patient care disputes. Broad-scale use of binding arbitration was pioneered by Kaiser-Permanente in California and has spread rapidly throughout the United States as managed care has become the predominant mode of medical care delivery. Patients' challenges to mandatory arbitration clauses generally have been rejected by the courts.<sup>11</sup> Significantly the Federal Arbitration Act,<sup>12</sup> as well as state laws in at least 40 states, provides a basis for enforcing these provisions.<sup>13</sup> However, because of the potential advantages for "repeat players," such as MCOs, these entities must meet specific legal requirements regarding their use of arbitrators and their participation in arbitration.

Because of the controversy surrounding the use of binding arbitration in malpractice disputes, the largest arbitration association in the United States, the American Arbitration Association (AAA), participates in the arbitration of medical malpractice disputes under mandatory binding arbitration clauses in managed care contracts only in limited circumstances. AAA participates in these arbitration proceedings only if the patient asks for arbitration or if the patient agrees to such a method for dispute resolution after the dispute arises.<sup>14</sup> With regard to the use of ADR in medical malpractice disputes, AAA, in conjunction with the American Medical Association and the American Bar Association, has drafted policy guidelines. These guidelines specify the following:<sup>15</sup>

- ADR can and should be used to resolve disputes over health care coverage and access arising out of the relationship between patients and private health plans and MCOs.
- ADR can and should be used to resolve disputes over health care coverage and access arising out of the relationship between health care providers and private health plans and MCOs.
- In disputes involving patients, binding forms of dispute resolution should be used only when the parties agreed to do so after the dispute arose.
- Due process protections should be afforded to all participants in the ADR process.
- Review of managed health care decisions through ADR complements the concept of internal review of determinations made by private MCOs.

It is not yet clear how or whether these policy guidelines will substantively affect the use of arbitration in malpractice disputes because of the significant number of non-AAA arbitrators available and the standard nature of these clauses in patient care contracts.

## ALTERNATIVE DISPUTE RESOLUTION AND OTHER MEDICAL DISPUTES

Aside from the controversial use of ADR in medical malpractice conflicts, a large number of potential disputes in the health care arena are amenable to ADR processes.

Because health care has become increasingly commercialized, ADR processes can address commercial disputes between facilities and those between facilities and medical providers in the same way that other commercial disputes are addressed. However, the provider's reputation, the health of a party, and the emotional concerns intimately related to illness, disease, and treatment make disputes in the health care arena unique. Some circumstances, such as end-of-life situations, simply are not well suited to ADR or formal adjudication. However, by assessing each party's needs and goals in the context of the specific social and medical circumstances, as well as their underlying incentives, an appropriate dispute resolution strategy can usually be ascertained.

Examples of voluntary applications of ADR to several modern medical disputes outside the malpractice context follow.<sup>15</sup> These examples illustrate the process of choosing a particular ADR method but are not definitive statements on health law or policy.

### Example 1: An Interfacility Dispute

#### Background

In the current health care climate, cost control has been a predominant consideration in the allocation of medical resources. As a result, federal, state, and local governments have used various strategies to minimize health care costs. One strategy has been to limit potential demand for expensive diagnostic technology by limiting the availability of such technology through requiring state-level approval before this type of asset can be purchased. However, if a health care facility can demonstrate to the state authority that there is sufficient patient need, there is no overlap between this form of capital investment and services derived therefrom, and there is available money to purchase and support the equipment, the facility may be granted a so-called certificate of need (CON), which is a permit that allows the facility to acquire such equipment. Such a grant is valuable because of the highly exclusive nature of the grant and the concomitant income arising therefrom.

#### Case Scenario

In a local city, St. Francis Hospital has merged with Johnson City Hospital. Each hospital has been under pressure to expand services and improve reimbursements obtained from their patients' insurance. Both are located in the same urban area but in different neighborhoods. St. Francis is a nonprofit, private facility that caters primarily to middle-class patients in its neighborhood. Johnson City Hospital is a nonprofit, private, inner-city facility established during the forgone days of prosperity in its community. Its current clientele consists of poor, disenfranchised patients who primarily are Medicaid program participants or are uninsured. Johnson City Hospital is a teaching hospital for the prestigious Physicians and Surgeons Medical School (P & S), which is located in the city. It is thus staffed with outstanding resident physicians (house staff) who supplement the hospital's retained attending physicians.

St. Francis and Johnson City merged just over one year ago. Subsequent to the merger, the hospital applied for and

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obtained a CON for a new magnetic resonance imaging (MRI) machine that would significantly enhance physicians' ability to diagnose disorders in emergency and other clinical situations. The hospital was granted the CON on the basis of Johnson City's locale (health care resources there are limited) and St. Francis' fiscal soundness, which would allow purchase and maintenance of the machinery.

The current dispute is over where to locate the MRI machine. Johnson City contends that the machine should be located at its facility because CON approval was based on its patients' medical needs. St. Francis' position is that the machine could not have been purchased without its funds, and thus the machine should be located at St. Francis. The state authority has expressed no opinion on the matter. There is vague talk of legal action by the parties. How can this dispute be settled?

From an ADR standpoint, before the methodology can be chosen, the goals of the parties must be ascertained. From Johnson City's point of view, the MRI machine should be located on its site primarily for financial reasons. Reimbursement for MRI procedures is relatively high compared with operational costs, and Johnson City has lost significant revenues by not having such services available. In addition, if Johnson City had the MRI machine, P & S would likely send more of its house staff to Johnson City. This action would reduce certain staff costs because P & S pays the salary of the house staff, and an increase in the number of house staff would reduce the need to employ other health care providers. Finally, Johnson City's patient population would be better served by having advanced diagnostic equipment, such as an MRI machine, available on site. When Johnson City physicians refer patients elsewhere for an MRI procedure, the patients often do not follow through with the referral to obtain the scan.

St. Francis has similar goals. It also wants to take advantage of the high reimbursement rate for MRI services. However, it also wishes to use the MRI machine as a marketing tool. The marketing department envisions hosting an event and running advertisements using the phrase "St. Francis and the Twenty-First Century: Bringing Advanced Health Care to the Community."

#### Alternative Dispute Resolution Assessment

The continuing relationship between St. Francis and Johnson City mitigates against the desirability of formal adjudication. The nature of the dispute (not involving novel legal issues or the desire to establish precedent) also makes formal adjudication inappropriate.

Arbitration is a possibility. Advantages include involvement of an arbiter who has expertise in the area, thus ensuring that technical arguments can be made, and who can issue a final decision. Additional advantages include confidentiality, relatively low cost, and rapid resolution, as compared with formal adjudication. Most likely, both parties would find all of these characteristics agreeable. However, arbiters' decisions usually are based on objective standards because arbitration is a rights-based procedure. In this case there is no clear-cut, single objective standard: the CON application apparently does not decide the issue; the state

authority has expressed no opinion; the law does not seem to apply; and a rights-based process may sully the future relationship between the parties. Furthermore, the possibility of either party withdrawing its support (Johnson City's patient base and St. Francis' money) would likely preclude acquisition of the MRI machine. Finally, arbitration does not fare well as compared with other ADR methods in terms of relative cost, speed, and ability to improve the parties' relationship by focusing on their joint interests. Thus there appear to be some significant disadvantages in using arbitration to settle this dispute.

Mediation provides potential for clarifying communication and allowing for a creative resolution of the dispute without the necessity of revisiting the divergent motivation for the CON application. The mediator also can take into account the possible internal pressures from the marketing department at St. Francis. Because the mediation process can focus on the future of the relationship and the joint interests of the parties, it can provide a foundation for building consensus between the hospitals. As well, because these parties are relatively new partners, a creative solution could spur additional, innovative joint ventures while simultaneously providing for and integrating into the process a communications pattern that takes into account the important allocative decisions that affect an organizational entity with separate and distinct sites. Furthermore, an evaluative course of action, providing both parties with the opportunity for reflection and feedback, could be integrated into the process for each joint project so that important lessons are learned from each effort. These lessons of course could and should be applied to future projects. Thus mediation has many advantages in this situation.

Within this purview, it appears that evaluative hybrid methods would be inappropriate. For example, a summary jury trial, which is best for disputes involving a disparate view of the facts and the law by opposing parties, would be inappropriate because the parties do not disagree on the governing law. In addition, early neutral evaluation has similar limitations.

Thus in this interfacility dispute a mediation process might be proposed by appropriate representatives from the two hospitals. The mediation process fits best with the underlying sources of the dispute and addresses these issues from the perspective of an ongoing relationship with much promise for the future. It allows for the application of creative, mutually beneficial solutions. Because both parties have a strong incentive to come to the bargaining (or mediation) table (the valuable property interest that they jointly own, or the CON), the likelihood for a successfully mediated settlement is enhanced. Mediation also could provide for retrospective analysis of the conflict, which can teach important lessons to be applied in the future.

Although it meets some of the needs to clarify past miscommunications, arbitration does not look to the parties' future relationship. Moreover, it requires some relatively objective standard for dispute resolution that is not available. Finally, law-based processes (evaluative hybrids), as well as formal adjudication, seems inapplicable in this type of case because of the ambiguity of applicable legal rules.

## Example 2: An Intrafacility Conflict— Exclusive Contracts and Provider Termination

### Background

To procure necessary health care services, it is extremely common for health care facilities to contract for these services either with a single physician or with physician groups as independent contractors. This contractual arrangement thus allows the health care facility to offer 24-hour physician services in the particular specialty and avoids the necessity and the expense of providing health, retirement, and other benefits to these individuals.

In this regard, hospitals use an exclusive contract for hospital-based physician services. Hospitals typically contract with physicians for a specified time with the stipulation that, if given the amount of notice specified in the agreement, either the hospital or independent contractor physician may terminate the contract without cause.

Thus these contracts are double-edged swords. On the one hand, within the period for which the exclusive contract is applicable, the physician or physician group has the right and the power to charge for all physician services in the specialty, to the exclusion of other, nonexclusive contract physicians. On the other hand, the hospital has the power to terminate the relationship for any or no reason at all after giving the requisite notice as indicated in the contract.

### Case scenario

Drake Hospital is a relatively large (450-bed) community hospital located in an affluent suburb. It serves primarily middle- to upper-class patients in the area and offers all of the major medical specialty services. Virtually none of the patients who come to Drake receive Medicaid benefits. Those who receive care from the hospital uniformly report satisfaction with its services. Patients generally find the new physical building, available parking, and courteous staff quite pleasing. The cafeteria is modern, and its food is delicious. Private physicians enjoy the facility's amiable atmosphere, delicious food, and private patient population.

Dr. Smith is a board-certified radiologist at Drake. After graduating from P & S and doing his residency training there, Dr. Smith entered private practice at Drake. Dr. Smith has worked at the hospital for the past 21 years under an exclusive contractual arrangement. Under the terms of the contract, Drake pays Dr. Smith a small salary; this salary is supplemented by charges to the hospital and referred patients' third-party insurers for rendered radiology services (as is normal practice). Dr. Smith also sees several of his own patients who come to Drake for specific radiologic procedures. For example, he performs and interprets chest x-ray films for a patient who was diagnosed several years ago with Hodgkin's disease and underwent curative radiation therapy but requires annual radiologic films to check for any recurrence. There have never been any allegations regarding the quality of care provided by Dr. Smith. Two years ago, Dr. Smith was awarded Drake Hospital's community

service award for distinguished and long-term service to the hospital and its patients.

One month ago, Dr. Smith was in the radiology department reading room interpreting some MRI scans when a hospital administrator entered the room. The administrator asked to speak with Dr. Smith in private. When both were in Dr. Smith's office, the administrator told Dr. Smith: "As you know, in about 3 months your contract is up for renewal. We on the board have been happy with the work you've done, but we are not going to renew your contract. We just think it's time for some new blood."

After the administrator left, Dr. Smith sat alone and thought: "Why is this happening? This place is more than a workplace for me; this can't be happening. What can an older physician do for money? This shouldn't be happening; they don't have the right to sully my reputation. Should I contact an attorney? I'm going to challenge this somehow." Dr. Smith then finished up the MRI readings for the day and left for home.

### Alternative Dispute Resolution Assessment

The goals of the parties in this situation are not entirely clear. The hospital board wants to terminate Dr. Smith, and it appears that this action is well within its contractual and legal rights. A question is raised regarding why the board wants to terminate Dr. Smith, particularly in light of his service to the facility and the fact that they are happy with his work.

From Dr. Smith's perspective, termination results in the prospect of unemployment. Furthermore, concerns regarding reputation are evident. It is clear that Dr. Smith would like to stay at Drake if possible. He apparently has significant emotional ties to the hospital. However, it is also clear that Dr. Smith is contemplating legal action.

Because the goals of the hospital administration are unclear or unexpressed, there may be a lack of good communication between the parties. Perhaps the administrator was uncomfortable explaining to Dr. Smith that the board felt he was getting too old to maintain the rigors of a full-time practice. Or, although happy with Dr. Smith's services, the hospital board may have been offered a lower-cost contract by another radiologist or radiology group. Thus a method of dispute resolution that addresses this communication problem would be best.

From this assessment, mediation most likely would be an appropriate choice. The nature of the dispute seems to require the exchange of more information or the disclosure of new information. The parties must learn more about their respective interests. Given the apparent difficulty in communication, mediation may provide a sensitive and reasonable forum in which the dispute can be resolved.

Dr. Smith, however, appears to have conflicting goals that affect the choice of forum. On the one hand, Dr. Smith wishes to keep his radiology position at the hospital. Thus a continuing relationship is desired. However, it also appears that Dr. Smith has strong feelings that termination would be inappropriate. Furthermore, there is a concern that his reputation will suffer.

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In contract disputes involving physicians, this potential effect on reputation is an important concern. There are few other professions to which this concept applies so broadly and to such a great degree. For Dr. Smith, reputation relates to patients, as well as to other physicians. If other physicians attempt to refer patients to Dr. Smith and he is required to inform them that he no longer has privileges at Drake, then there may be some implication of questionable competence or poor quality of care. Furthermore, if Dr. Smith attempts to find other work, the same reputational problems may arise. Although Dr. Smith sees some private patients at the hospital, the majority of his income is derived from hospital practice and referrals from other physicians. Accordingly, reputation becomes a significant concern to Dr. Smith as he considers actions involving (and possibly against) the hospital.

Thus, on one hand, a clearer understanding of the issues (the “why is this happening” factor), the desire to continue as the radiologist at the hospital, and the emotional ties might point toward a mediation approach. On the other hand, Dr. Smith’s desire to maintain his reputation in the community (and with respect to other potential employers) would favor some other form of dispute resolution.

In this case a combination of mediation and arbitration might be optimal. Perhaps a mediation-advisory arbitration rather than a mediation-binding arbitration would be best because the latter form has some significant disadvantages as applied to this situation. First, there is a high probability that the hospital board members would not want to be completely candid when discussing their decision to renew Dr. Smith’s contract if they knew that there could be a binding decision later. Thus the mediator would have relatively little information with which to work when attempting to help the parties craft a jointly creative and beneficial solution. Furthermore, because subsequent arbitration may focus on whether one party is “right” (hence changing the dynamic so as to divert the dispute resolution process away from interest-based solutions to the conflict), the parties may be less likely to try to resolve the problem at the mediation stage. Indeed, the parties may make a significant effort to convince the mediator that one or the other is deserving of a favorable decision.

The hospital most likely would not wish to enter into a binding process and risk losing when it is in a favorable legal position. Nevertheless, the hospital may wish to enter into an ADR procedure to avoid the legal costs of formal adjudication and eschew negative publicity. Moreover, certain “emotional” considerations may induce Drake administrators to treat Dr. Smith in a fair manner.

Mediation-advisory arbitration could address the disadvantages of mediation-binding arbitration. First, advisory arbitration is just that, only advisory. Advisory arbitration would preserve the creative solution emphasis and restore the mediation dynamic to the process rather than focus on a determination of who is “right.” Perhaps the mediator could open the lines of communication between the parties, allowing the parties to participate actively in the dispute resolution process. If mediation fails, an advisory position (an evaluative process) could give Dr. Smith and

Drake an objective assessment regarding the conflict and the outcome should the matter proceed to formal adjudication.

This process also could serve Dr. Smith’s need to address his reputational concern; the settlement or possibly an acceptable advisory opinion could expressly state that the hospital’s actions regarding Dr. Smith were not based on any quality of care concerns, or similar language to that effect. This statement would allow Dr. Smith to seek employment with other providers and show that a neutral third party had found (and the hospital had stated) that no quality of care issues triggered his change in status at the hospital.

However, a possible disadvantage of mediation-advisory arbitration is the potential length of the process. With both mediation and advisory arbitration, time may be spent on adjudicatory arbitration or formal court activity in addition to the extra step of advisory arbitration. However, empirical data suggest that there is a significant possibility that the dispute could be resolved without resorting to formal adjudication.

Thus, in this physician termination scenario, mediation-advisory arbitration appears to be appropriate. Pure evaluative procedures, such as summary jury trial and early neutral evaluation, could be helpful if there were a different view of the legal rights of the parties. In this case the hospital has the authority to terminate Dr. Smith’s contract. Arbitration, although possibly favorable to the hospital, would not serve Dr. Smith’s interest-based concerns and, as a single method, would be inappropriate.

## CONCLUSION

Disputes regarding medical care delivery are common. Many of these disputes can be addressed and resolved using ADR methods in combination with formal adjudication. An understanding of the various ADR methods, their strengths and weaknesses, their legal status, and the interests and goals of each party can usually but not always bring about an effective resolution to the dispute in the health care context.

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## Endnotes

1. C. Guadagnino, *Malpractice Mediation Poised to Expand*, [www.physiciansnews.com/cover/404.html](http://www.physiciansnews.com/cover/404.html). Published April 2004; visited May 28, 2006.
2. *Rush Hospital’s Medical Malpractice Mediation Program: An ADR Success Story*, [www.ctsnet.org/doc/4380](http://www.ctsnet.org/doc/4380). Last revised Apr. 24, 2000; visited May 28, 2006.
3. *Governor Rendell Announces Medical Malpractice Liability Proposals*, [www.state.pa.us/papower/cwp/view.asp?A=11&Q=436418&papowerNav=|31734|](http://www.state.pa.us/papower/cwp/view.asp?A=11&Q=436418&papowerNav=|31734|). Published March 2004; visited May 28, 2006.
4. See, e.g., Federal Arbitration Act, 9 U.S.C.A. §§2 *et seq.*; see also Administrative Dispute Resolution Act, 5 U.S.C.A. §§5581–5593;

- Ariz. Rev. Stat. Ann. §§12-1501 to 12-1518 (West 1994); Ark. Code Ann. §§16-108-201 to 16-108-224 (Mich. 1995); Del. Code Ann. tit. 10 §§5701-5725 (1996); Fla. Stat. ch. 682.01-682.22 (1990); Idaho Code §§7-901 to 7-922 (1990); Iowa Code Ann. §§679A.1-679A.19 (1987); Kan. Stat. Ann. §§5-401 to 5-422 (1995); Ky. Rev. Stat. Ann. §§417.145-417.240 (Michie 1996); Minn. Stat. §§572.08-572.30 (1996); Mont. Code Ann. §§27-5-111 to 27-5-324 (1996); Nev. Rev. Stat. §§38.015-38.360 (1995); N.J. Stat. Ann. §§2A:23A-1 to 2A:23A-19 (West 1996); Ohio Rev. Code Ann. §§2711.01 to 2711.16 (West 1992); Pa. Cons. Stat. §§7301-7320 (1982); R.I. Gen. Laws §§10-3-1 to 10-3-21 (1996); S.D. Codified Laws §§21-25A-1 to 21-5A-38 (Michie 1996); Tenn. Code Ann. §§29-5-301 to 29-5-320 (1996); Utah Code Ann. §§78-31a-1 to 78-31a-20 (1996); Vt. Stat. Ann. tit. 12, §§5651-5681 (1996); Wyo. Stat. Ann. §§1-36-101 to 1-36-119 (Michie 1986).
5. See, e.g., Cal. Health & Safety Code §1373.19 (indicating that single arbitrator may assess claims for health services claims up to \$200,000); Hawaii Arb. Rules, Rule 8 (Michie 1995) (monetary claims for amounts less than \$150,000 must go to court-annexed arbitration except under certain circumstances).
  6. See, e.g., Ark. Code Ann. §16-108-201(b) (Michie 1997); Kan. Stat. Ann. §5-401(c) (1997); Mont. Code Ann. §27-5-114 (2) (1997); S.C. Code Ann. §15-48-10 (1998); Tex. Civ. Prac. Code Ann. §171.001 (1997).
  7. See *Assami v. Assami*, 872 P. 2d 1190 (Cal. 1994); *Estate of Kent*, 57 P. 2d 901 (Cal. 1936); *Solorzano v. Sup. Ct.*, 22 Cal. Rptr. 2d 401 (Cal. 1993).
  8. See, e.g., Tex. Alcoholic Beverage Code §102.77 (parties must pay for arbitration costs); Fla. Stats. Ann. §44.103; Fla. Alt. Disp. Res. §718.1255 (mandating voluntary mediation and mandatory nonbinding arbitration).
  9. See, e.g., Cal. Civ. Pro. §1295 (describing wording, font, and color of enforceable medical malpractice arbitration agreement) subject to federal law.
  10. See, e.g., *Perry v. Thomas*, 482 U.S. 483 (1987) (state laws that are unique to arbitration agreements are preempted by federal law governing arbitration).
  11. See, e.g., *Coon v. Nicola*, 21 Cal. Rptr. 2d 846 (Cal. Ct. App. 1993); *Buraczynski v. Eyring*, 919 S.W. 2d 314 (Tenn. 1996); *Broemmer v. Otto*, 821 P. 2d 204 (Ariz. 1991); *Wilson v. Kaiser Found. Hosps.* 190 Cal. Rptr. 649 (Cal. Ct. App. 1983); *Dinong v. Kaiser Found. Hosps.*, 162 Cal. Rptr. 606 (Cal. Ct. App. 1980); *Madden v. Kaiser Found. Hosps.*, 131 Cal. Rptr. 882 (Cal. 1976) (all upholding use of ADR); but see *Colorado Permanente Med. Group v. Evans*, 926 P. 2d 1218 (Colo. 1996); *Saika v. Gold*, 56 Cal. Rptr. 2d 922 (Cal. Ct. App. 1996); *Beynon v. Garden Grove Med. Group*, 161 Cal. Rptr. 146 (Cal. Ct. App. 1980); but see *Rosenfield v. Sup. Ct.*, 143 Cal. App. 3d 198 (Cal. 1983); *Graham v. Scissor-Tail, Inc.*, 28 Cal. 3d 807 (Cal. 1990); *Cheng-Canindin v. Renaissance Hotel Assocs.*, 50 Cal. App. 4th 676 (Cal. Ct. App. 1996).
  12. 9 U.S.C.A. §2.
  13. P.I. Carter, *Binding Arbitration in Malpractice Disputes: The Right Prescription for HMO Patients?*, 18 Hamline Journal of Public Law and Policy 423-451 (1997).
  14. G.H. Friedman, *AAA, ABA and AMA Issue Joint Resolution: Recommendations for Health Care Dispute Resolution*, 15 Med. Mal. L. Strategy 1 (1998).
  15. B.A. Liang, *Understanding and Applying Alternative Dispute Resolution Methods in Modern Medical Conflicts*, 19 J. Legal Med. 397-430 (1998).

## Internet References

### Alternative Dispute Resolution Resources

<http://adrr.com>

American Arbitration Association

<http://www.adr.org>

American Bar Association Section of Dispute Resolution

<http://www.abanet.org/dispute>

Chartered Institute of Arbitrators

<http://www.arbitrators.org>

Conflict Research Consortium

<http://www.colorado.edu/conflict>

CPR Institute for Dispute Resolution

<http://www.cpradr.org>

Georgetown University ADR resources page

<http://www.ll.georgetown.edu/lr/rs/adr.html>

Guide to Alternate Dispute Resolution

<http://hg.org/adr.html>

Institute for Conflict Analysis and Resolution

<http://web.gmu.edu/departments/ICAR/>

Law Forum: Alternative Dispute Resolution

<http://www.lawforum.net/services/alternative.htm>

Mediation Information and Resource Center

<http://www.mediate.com>

Program on Negotiation at Harvard Law School

<http://www.pon.harvard.edu>

Self-Administered ADR: Its Advantages and How it Works

<http://www.cpradr.org/selfadm.htm>

