Mandatory Pre-Suit Mediation for Medical Malpractice: Eight-Year Results and Future Innovations

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Situated in the litigious state of Florida, UF Health implemented its mandatory pre-suit mediation program in 2008 to compensate meritorious medical malpractice claims quickly, combat increasing attorney fees and costs, reduce frivolous lawsuits, and facilitate early, confidential communication to enhance the patient-provider relationship. Data analysis over the program's eight-year history demonstrates positive impacts on legal expenses and resolution time; results show a reduction in legal expenses of 87 percent as compared to traditional litigation and average receipt-to-resolution time of less than six months. The authors examine the Florida infrastructure supporting the program's success and offer recommendations for future expansions.

Jenkins, Smillov, and Goodwin (2014) documented the success of the Florida Patient Safety and Pre-Suit Mediation Program (FLPSMP) over a period of five years "to provide deserving patients with fast, fair compensation while limiting the healthcare provider expenses incurred during traditional litigation" (15). Beyond demonstrating the continued success of the program with an additional three years of data, this review explains the unique aspects of Florida mediation laws and Florida infrastructure that support early pre-suit mediation and offers recommendations for future expansion innovations, including conflict resolution education at the provider level and even earlier voluntary mediation opportunities to facilitate difficult conversations.

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Background: The High Economic and Societal Costs of Traditional Medical Malpractice Litigation

In the United States, the traditional medical malpractice system costs more than $55.6 billion annually (Mello, Chandra, Gawande, and Studdert 2010). According to a 2015 Aon Risk Solutions (Aon) and American Society for Healthcare Risk Management (ASHRM) benchmark analysis, Florida's loss rate—a combination of average claim costs to resolve and annual volume of claims—is the highest among all states, at 2.9 times the national average. In South Florida, a notoriously plaintiff-friendly jurisdiction, closed-claim figures among claims with indemnity over twelve years average $607,000, compared to the average closed-claim figure of $374,000 nationwide (Aon and ASHRM 2014).

Major categories of economic costs in the current liability system include indemnity payments and legal expenses. Particularly when cases are litigated over a long period, legal expenses can thoroughly erode any settlement amount that patients ultimately retain. Initiating legal proceedings with an attorney on contingency essentially guarantees, at a minimum, that 30 percent of either settlement payment or jury award remains with the lawyer. In addition, the patient/claimant is responsible for all legal expenses associated with the litigation, including expert witnesses and court fees. Statistically, fifty-four cents of every dollar of compensation procured through formal litigation are consumed by legal expenses and costs (Studdert et al. 2006).

In addition to these economic costs, the traditional malpractice litigation system involves delays, inefficiencies, and uncertainties that expose patients and providers to societal costs, including emotional effects and temporal waste, which are more difficult to evaluate in monetary terms. By incorporating a mandatory, pre-suit mediation agreement into the informed consent process, University of Florida Health (UF Health) has effectively reduced the economic and noneconomic costs of traditional litigation by using FLPSMP. As this article details, based on data gathered over FLPSMP's first eight years, the program results in months' faster resolution of claims and, accordingly, expedited and increased net compensation to deserving patients, as well as lower legal costs for all parties by fostering early, confidential communication between patients and providers.

The Florida Patient Safety and Pre-Suit Mediation Program

FLPSMP went into effect on January 1, 2008, across UF Health, which includes the six colleges of the University of Florida J. Hillis Miller Health Science Center (Dentistry, Medicine, Nursing, Pharmacy, Public Health, and Veterinary Medicine), Shands teaching hospital and clinics, physician practices, institutes, centers, programs, and support services. FLPSMP was designed to meet three objectives—compensate deserving patients in a fair and timely manner; facilitate accurate and timely provider-patient communication (including patient safety improvements when identified); and reduce frivolous lawsuits—as well as associated costs and expenses for all parties.

Implementation of FLPSMP begins at admission to a UF Health facility when patients are required to sign a pre-suit mediation agreement before receiving medical care whereby they agree to participate in mediation prior to filing a malpractice lawsuit—for example:

> Agreement to Mediate—In accepting care at this facility where UF employees and/or agents provide medical care and treatment, I agree that before I file any lawsuit against the UF Board of Trustees for medical care and treatment rendered by its health care providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party who has been certified to be a mediator tries to help settle claims. UF Health will pay the cost of the mediator. I further agree that any mediation must take place in the state and county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain time period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

Mediation is a dispute resolution mechanism wherein a neutral third party (the mediator) assists the other parties in negotiating a mutually acceptable settlement. Generally each party has an opportunity to present facts and arguments in support of their position, and the mediator helps the parties to negotiate and attempt to reach an agreement. The mediator's role is to be neutral and impartial, and the parties are the ultimate decision makers. Notably, Florida laws favor mediation; Section 766.108 of

the Florida Statutes mandates in-person mandatory mediation of medical negligence actions within 120 days after suit is filed, and many cases are referred to mediation by the assigned trial judge at least one additional time before the date set for trial. Thus, the patient who agrees to the FLPSMP provisions is agreeing only to participate in mediation earlier than required by Florida law in the event of a lawsuit, and patients are allowed to bring an attorney to mediation.

Consenting to attend pre-suit mediation in no way obligates the patient or any other party to consent to any proposals offered in mediation. Like these statutorily required and court-ordered mediations, the FLPSMP does not restrict access to court or limit patients' rights to pursue traditional litigation if mediation is unsuccessful. Rather, the program affords the parties an even earlier and less costly opportunity to resolve claims. A key advantage of FLPSMP is the ability for unhappy patients and their representatives to enjoy the benefits of mediation within months of treatment without having to incur the significant time delay (often years) and costs associated with formally pursuing a medical malpractice lawsuit.

Through open patient-provider communication, fostered by the confidential mediation setting, the FLPSMP process creates opportunities to resolve conflict promptly, which encourages patients to forgo litigation where high costs may reduce net recovery. Systematic implementation of FLPSMP has produced a template for replication beyond Florida, empowering providers and patients nationwide to realize the benefits of this effective alternative to medical malpractice litigation, using early, confidential mediation and constructive patient-provider communication.

Overwhelmingly, the primary reason a patient pursues a medical malpractice claim is a breakdown in the clinician-patient relationship, most often resulting from unsatisfactory communication (Huntington and Kuhn 2003). The need for an explanation as to how and why an injury occurred outranks the desire for compensation among leading reasons that patients initiate litigation (Huntington and Kuhn 2003). FLPSMP allows for patients and providers to share information with additional statutory protections to protect privacy and promote candor.

Analysis of FLPSMP: Eight Years of Data

We have analyzed data pertaining to claims received by UF Health from January 1, 2008, to December 31, 2015. As used in this study and reflected

in earlier publications regarding FLPSMP, a claim is a written or verbal allegation of malpractice and a request or demand for compensation against a physician or hospital employee (Jenkins, Smillov, and Goodwin 2014). For all claims resolved through FLPSMP, we calculated time from receipt of the claim to resolution. For comparative purposes, time losses inherent in traditional litigation have been approximately quantified by analyzing resolution times as reflected by national data on closed claims (Aon and ASHRM 2014, 2015).

We calculated the success rate of FLPSMP by comparing the number of claims resolved to the total claims mediated through the program. We recorded the times for average receipt-of-claim to resolution over an eight-year period as compared to reported nationwide averages. In addition, we recorded the allocated legal expenses for each settled claim and reported the average paid for each of the eight years in the study period.

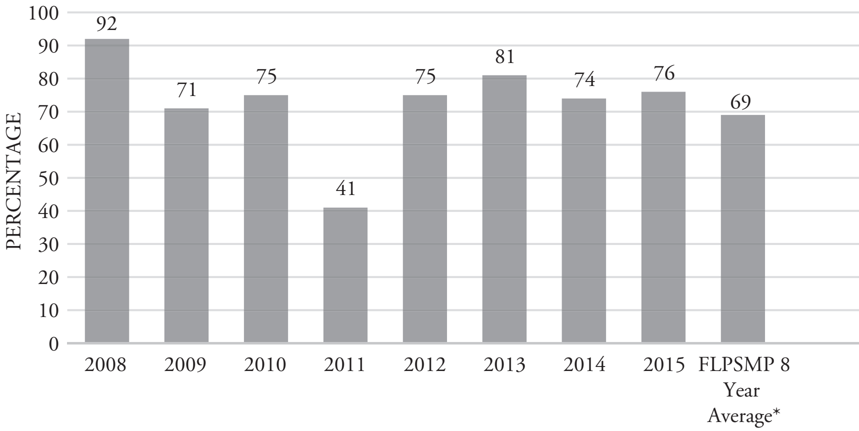
Results

For claims resolved through FLPSMP, average receipt-to-resolution time was reduced to less than six months, in sharp contrast to years-long traditional medical malpractice litigation. Defendant legal expenses were also dramatically reduced by 87 percent compared to the national average. Increased efficiency in resolution resulted in reduced legal fees and expenses to claimants, increasing their net proportionate recovery beyond the 22 to 46 percent retained in formal litigation.

These positive results touch the vast majority of claims mediated through FLPSMP, which has proven successful in resolving almost 70 percent of claims at mediation over the life of the program. Figure 1 illustrates FLPSMP's average success rate by percentage of mediated claims resolved for each year of the program. Figure 2 depicts the status of all claims mediated through FLPSMP as of December 31, 2015, by category: total number of claims submitted to mediation; number of claims settled at pre-suit mediation; number of claims resolved subsequent to pre-suit mediation; number of claims resolved without payment by virtue of the expiration of the applicable statute of limitations; and the number of claims remaining unresolved.

In both figures, 2011 distinguishes itself as an outlier, largely attributable to litigant reluctance to commit to a resolution pending clarification of significant proposed changes in laws affecting malpractice claims. The

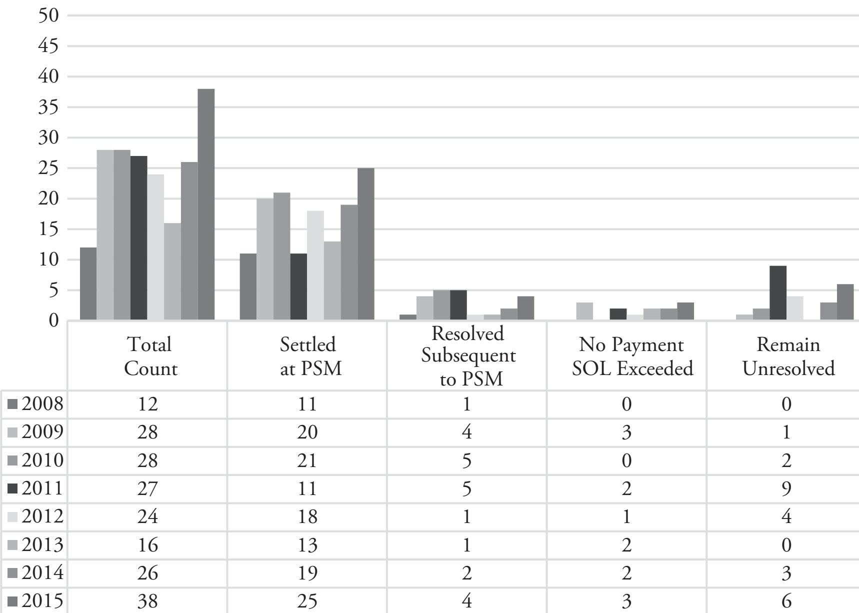
Figure 1. Settlement Rate by Year.



Source: Authors' analysis of UF Health self-insurance program pre-suit mediation and closed-claim data.

*Eight-year average determined through the aggregate of all program-year claims. Due to varying numbers of claims mediated per year, the eight-year average will not equal the average of all eight-year settlement rates.

Figure 2. Status of Mediated Claims.



	Total Count	Settled at PSM	Resolved Subsequent to PSM	No Payment SOL Exceeded	Remain Unresolved
2008	12	11	1	0	0
2009	28	20	4	3	1
2010	28	21	5	0	2
2011	27	11	5	2	9
2012	24	18	1	1	4
2013	16	13	1	2	0
2014	26	19	2	2	3
2015	38	25	4	3	6

Source: Authors' analysis of UF Health self-insurance program pre-suit mediation and closed-claim data.

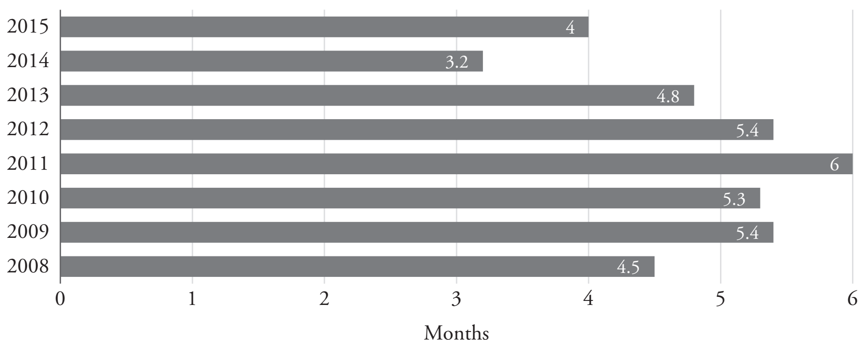
Note: PSM: Pre-suit mediation. SOL: Statute of limitations—the statutory time limit for bringing a civil case, based on the date when the claim was known or should have been known.

Florida legislature and appellate courts were reviewing matters vital to both plaintiffs' and defendants' abilities to make informed settlements on the validity of using a higher standard of care (recklessness versus the usual negligence standard) before a jury could find a breach of a provider's duty when treating patients presenting in unstable, emergent medical conditions (Fla. Stat. § 768.13 [2015]); requirements that prior to initiating litigation, a plaintiff must have an expert from the same specialty (previously a similar specialty was allowed) sign an affidavit that the standard of care had been breached (Fla. Stat. § 766.102(5)(a) [2015])); as well as courts considering the validity of the legislature's limitation on pain-and-suffering damages (*McCall v. United States* 2011).

A 2015 benchmark analysis produced by Aon and the American Society for Healthcare Risk Management indicates that nationwide, 55.6 percent of claims take more than a year to resolve (by any means), 26.6 percent take more than two years to resolve, and 11.5 percent take three years or more. By comparison, UF Health has reduced the average close time (the interval between the date a claim is received and the date a claim is resolved) to six months or less for all claims resolved through FLPSMP over the eight-year study period. Average close time has varied only marginally by individual FLPSMP year, as shown in Figure 3.

Over the first eight years of the program, FLPSMP reduced legal expenses by 91 percent in comparison to traditionally litigated claims in Florida and by 87 percent against the national average. For claims resolved with settlement amounts paid on behalf of providers, the average legal

Figure 3. Receipt of Claim to Resolution.

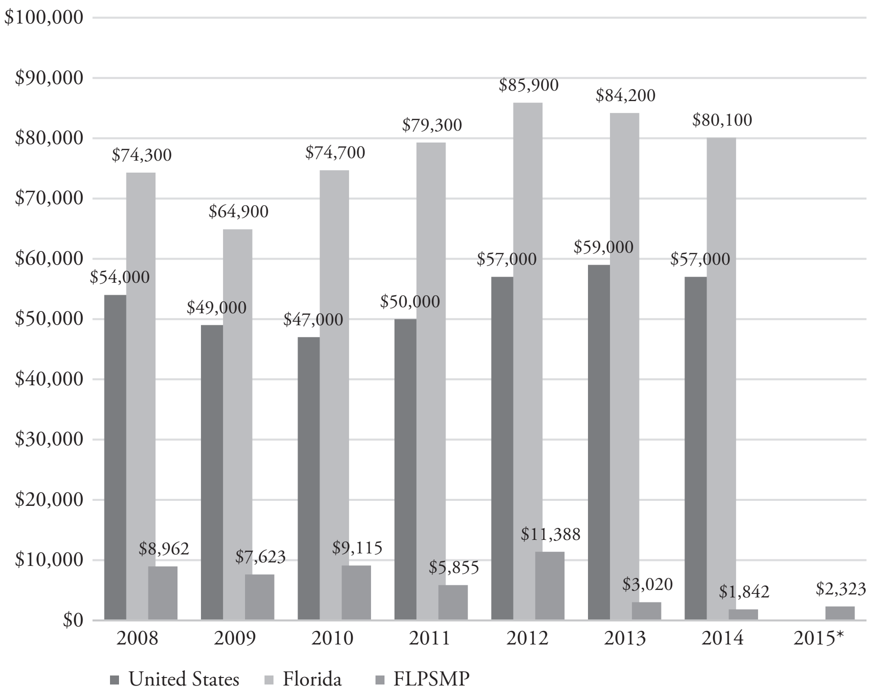


Source: Authors' analysis of UF Health self-insurance program pre-suit mediation and closed-claim data.

expense nationwide was $53,286 per claim; for Florida, it was $77,629 per claim (Aon and ASHRM 2014, 2015). By comparison, cases resolved through FLPSMP incurred an average legal expense of $6,911.91 per claim. Figure 4 illustrates a comparison of defendant legal expenses for claims resolved with indemnity payments in the United States and Florida, as compared to claims resolved through FLPSMP for 2008 through 2014. Although Florida and national closed-claim data for 2015 were not available at the time of publication, the average legal expense for claims resolved through FLPSMP during 2015 remained characteristically low at $2,322.69.

This reduction in legal expenses, augmented by using FLPSMP in-house counsel, reduces defense expenses, allowing funds to be focused on compensating meritorious claimants. Lower administrative costs and fees

Figure 4. Provider Legal Expenses.



Source: Aon and ASHRM (2014, 2015); authors' analysis of UF Health self-insurance program pre-suit mediation and closed-claim data.

*Data not available for United States and Florida at time of publication.

mean a higher percentage of retained recovery; therefore, a faster resolution through mediation, before a lawsuit is even filed, is a significant benefit to all parties. Once formal litigation begins, counsel for the plaintiff is generally entitled to 30 to 40 percent of the total compensation, as well as reimbursement for expenses. By contrast, early resolution through FLPSMP ensures that the vast majority of indemnity payment remains with the patient by reducing the 54 percent of compensation consumed by legal fees and costs.

Through structured, confidential patient-provider communication, the FLPSMP mediation process creates opportunities to resolve conflict promptly and avoid the emotional costs and uncertainties of protracted litigation. The average time between an occurrence of injury and the closure of a claim is five years (Mello et al. 2010). Once a medical malpractice case is filed, it lasts over three years and has a defense verdict rate between 73 and 81 percent (Hyman and Silver 2006).

The FLPSMP early mediation process contributes to patient safety by enabling providers to learn from potential claims and implement improvements years earlier than litigation through the traditional tort system. Since the average FLPSMP matter resolves in six months, opportunities shared by a patient, a patient's family member, or a representative during mediation regarding ways a provider or system may deliver better care could be shared and implemented with the health system much earlier than if the mediation discussion happened only a few months before trial, the norm for mediations in the traditional litigation setting. Systematic implementation of FLPSMP has produced a template for replication beyond Florida, empowering providers and patients nationwide to realize the benefits of mandating mediation communication as a preferred alternative to medical malpractice litigation.

Florida Mediation Infrastructure

The Florida legislature and courts have created a strong infrastructure in which pre-suit mediation can be constructively conducted. Of particular importance are Florida statutes that provide privacy protections for mediation communications and immunity for mediators. In addition, the Florida Supreme Court has established mediator certification qualifications, standards of professional conduct for mediators, and a mediator disciplinary process to safeguard the mediation process. These elements provide a strong infrastructure to promote both court-referred and pre-suit mediation.

Mediation Confidentiality and Privilege

Pre-suit mediations conducted by Florida Supreme Court–certified mediators are automatically covered by the Florida Mediation Confidentiality and Privilege Act (Fla. Stat. §§ 44.401—406 [2015]) unless the parties elect to waive the act's provisions. The act provides that mediation communications are confidential and can be shared only with another mediation participant or his or her counsel (Fla. Stat. §44.405(1) [2015]). In addition, the act provides that mediation communications are privileged and therefore inadmissible in court (Fla. Stat. § 44.405(2) [2015]). Certain exceptions to the confidentiality and privilege of mediation communications are also included in the act (Fla. Stat. § 44.405(4)(a) [2015]).

Mediator Immunity

Florida Supreme Court–certified mediators enjoy a degree of mediator immunity provided by Florida Statutes section 44.107(2). While a certified mediator can be grieved for failing to meet the standards of professional conduct for mediators, mediators "have immunity from liability arising from the performance of that person's duties while acting within the scope of the mediation function" unless the mediator "acts in bad faith, with malicious purpose, or in a manner exhibiting wanton and willful disregard of human rights, safety, or property" (Fla. Stat. §44.107(2)(c) [2015]). This protection from immunity provides a safe position from which mediators can assist parties who are embroiled or potentially may be embroiled in litigation. If the case is court ordered, mediators have the same immunity as a judge (Fla. Stat. § 44.107(1) [2015]).

Mediator Certification

Circuit civil mediators are certified by the Florida Supreme Court, which ensures a minimum quality of mediator education, training, mentorship, and good moral character. Mediators must complete a forty-hour Florida Supreme Court–approved mediation certification course and meet other requirements, including possessing a graduate degree (PhD, MD, JD, MA, or MS), completing a mentorship of mediation observations or supervised mediations with Florida Supreme Court–certified circuit civil mediators, and possessing good moral character (In re *Proposed Standards of Prof'l Conduct for Certified & Court-Appointed Mediators* 1992).

Standards of Professional Conduct

Mediators certified by the Florida Supreme Court and court-appointed mediators must adhere to the Standards of Professional Conduct established by the Court (Rules 10.200-10.690). In these standards, mediation is defined as "a process whereby a neutral and impartial third person acts to encourage and facilitate the resolution of a dispute without prescribing what it should be. It is an informal and non-adversarial process intended to help disputing parties reach a mutually acceptable agreement" (Rule 10.210). The role of the mediator is "to reduce obstacles to communication, assist in the identification of issues and exploration of alternatives, and otherwise facilitate voluntary agreements resolving the dispute. The ultimate decision-making authority, according to the rule, however, rests solely with the parties" (Rule 10.220).

Disciplinary Process for Mediators

While mediators enjoy a certain degree of immunity from civil lawsuit in a Florida court, complaints may be filed against mediators, and mediator certification can be revoked for cause by the Mediator Qualifications Board (Rules 10.700-10.910). Complaints are reviewed for facial sufficiency—that is, determining that the allegations, if found to be true, would constitute a violation of the Rules for Certified and Court-Appointed Mediators. If the complaint is found to be sufficient, an investigation may follow to evaluate probable cause. If appropriate, a mediator can consent to any sanctions mutually agreed to by a complaint committee, or the complaint can be forwarded to a panel that will hear the case and make a determination that may include a variety of sanctions including decertification of the mediator (Rule 10.840).

Suggestions for Future Innovation

Early Voluntary Mediation

Szmania, Johnson, and Mulligan (2008, 87) have recommended that "early intervention following unexpected medical outcomes should . . . be a key design consideration in dispute systems design." Similarly, Liebman and Hyman (2005, 2) have recommended that hospitals "offer early, non-evaluative mediation that brings patients or family members together with health professionals to share information and seek solutions." In addition, they write that hospitals should attempt to "provide communication training to doctors and administrators as part of changing hospital culture

from one of defensiveness to one of openness, create a 'consult service' of communication experts within hospitals to help plan conversations with patients and family members and provide emotional support to health care providers involved in errors or adverse events, [and] offer apologies when appropriate" (2). In conjunction with the already established mandatory pre-suit mediation program, early mediation could be offered on a voluntary basis in an attempt to facilitate the resolution of patient complaints and disclose any adverse events.

Such early mediation could reduce claim expenses even more while improving patient safety and satisfaction. While causality and negligence may not be clear early in a case, an early mediation program could allow for opportunities to address those circumstances where causality and negligence are clear or to address problems in a timelier manner when a greater variety of remedies may be available (Holman, Vidmar, and Lee 2011). On some occasions, it may be possible to conduct early mediation while care is still being provided. That could allow for improvements in patient care, as well as addressing what may be a host of related patient concerns.

In early mediation, issues other than compensation can also be addressed:

- Allowing the patient to feel heard and understood
- Answering the patient's questions concerning what happened
- Informing the patient of steps taken to prevent the problem from reoccurring
- Preserving the provider-patient relationship when desired
- Improving patient safety
- Disclosing adverse events

Early mediation could provide a confidential opportunity for health care providers to more openly address patients' questions and concerns and seek ways to address patients' concerns. When problems arise in patient care, there is a tendency to adopt a defensive communication mode, which has been defined as "a mode of interaction designed to protect practitioners from malpractice suits, but which, in fact, breeds conflict and serves as a barrier to resolution efforts" (Rabinovich-Einy 2011, 241). By using early confidential mediation, health care providers need not embrace such a defensive stance and can more freely talk with the patient about aspects of care and answer the patient's questions in a less stressful environment.

From about 2003 to 2011, Medicare operated a Medicare beneficiary mediation program that facilitated the resolution of Medicare beneficiary complaints that did not involve quality of care or financial issues (Centers for Medicare and Medicaid Services 2003). Based on the mediation experience of one of us, the program successfully resolved many patient complaints and sometimes raised the quality of patient care by encouraging health care providers to listen directly to and better understand and appreciate patients' concerns. Such encounters were often the basis for corrective action to address circumstances that triggered patient complaints.

Since it appears that poor communication between medical staff and patients and their families can be a triggering event for a malpractice lawsuit, early voluntary mediation, which improves communication, holds the promise of resolving patient complaints at an earlier time and possibly reducing the likelihood of future litigation (Rabinovich-Einy 2011). In addition, early mediation can resolve dissatisfaction with the quality of care by hearing patient grievances, providing additional explanations, and offering apologies when appropriate, among other issues. Early mediation may also help to increase patient satisfaction with patient care and thus contribute to improved hospital satisfaction scores from patients.

Improving patient satisfaction can result in increased hospital revenues in the Medicare value-based purchasing model of reimbursement where quality of care scores affect reimbursement rates. Of particular significance, one measure of quality of care under the value-based purchasing model is the patient experience of care (PEC). PEC is a measure in part of patient satisfaction and PEC scores contribute to the overall value-based purchasing formula for determining reimbursement rates for hospitals. PEC measures include communication with nurses and doctors, responsiveness of hospital staff, pain management, cleanliness and quietness of the hospital environment, communication about medicines, discharge information, and the overall rating of the hospital (Centers for Medicare and Medicaid Services 2014).

As this list makes clear, many of the PEC factors involve communication. To the extent that early voluntary mediation improves communication and resolves some issues in a more timely manner, early mediation holds the promise of increasing hospital PEC scores and thereby possibly increasing hospital revenues.

Thus, using an early voluntary mediation option in addition to the mandatory pre-suit mediation could serve to promote earlier resolution of patient complaints, reduce the likelihood of later lawsuits, and increase hospital reimbursement rates. In such a two-tiered mediation

model, participation in the early voluntary mediation would not be a substitute for participation in the mandatory mediation; rather, it could be a supplement to the hospital's conflict resolution efforts.

Conflict Resolution Education

Hospitals should establish meaningful conflict resolution education and training to further reduce the number of patient complaints and problems associated with medical errors by teaching effective communication, interest-based negotiation, and conflict resolution skills to hospital health care providers and staff. Such training for health care professionals would be an essential part of improving patient safety and the patient hospital experience at the same time it reduces possible future litigation.

In addition to improving communication with patients, such conflict resolution training might also help hospital providers, staff, and administration to better communicate with one another. In health care, the tendency to avoid conflict is significant (Kressel, Kennedy, Lev, Taylor, and Hyman 2002). Since conflicts among health care providers can contribute to an increased likelihood of medical errors, teaching health care conflict resolution skills would appear to be essential to improving patient care and the patient's experience of care (Baldwin and Daugherty 2008).

Further Research

Anecdotally, both plaintiffs and plaintiff attorneys who have participated in the FLPSMP process seem to have overwhelmingly voiced their support: plaintiffs prefer swift resolutions, and attorneys prefer to know case challenges prior to spending years of time and several tens of thousands of dollars pursuing a matter that may be fiscally disadvantageous. A survey of participating plaintiffs and plaintiff attorneys should be conducted in order to show quantifiably if the program is well received due to, or in spite of, its early settlements. Without a full quantitative study, it is impossible to eliminate detection bias because plaintiffs or plaintiff attorneys who seem to be displeased with mediation may be less likely to be inquired.

Conclusion

The demonstrated success of the mandatory pre-suit mediation program provides encouragement to expand the use of collaborative strategies to more constructively resolve malpractice claims. A two-tiered mediation

model incorporating early voluntary mediation and mandatory pre-suit mediation, coupled with conflict resolution training, represents the logical next step. A more comprehensive approach should help to further reduce the time to resolve patient concerns and adverse events, reduce unnecessary expense for patient and provider, improve patient safety and satisfaction, and increase insurance reimbursement revenues in circumstances where value-based purchasing models are used.

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