Medical Malpractice System in the United States of America:
Lesson to Learn for Indonesia

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Abstract
A system that serves the liability and settlement of medical malpractice disputes or
commonly referred to as medical malpractice system has been established in many
countries to respond the rise of medical malpractice claims against doctors. Medical
malpractice system in the United States of America (the USA) has been relatively
well developed as compared to other countries. Beside adopting pretrial screening
process in medical malpractice litigation, various methods of alternative to litigation
have been developed in the USA. This paper aims to explore the development of the
medical malpractice system in the USA and to see the possibility for Indonesia to
learn. This normative legal research relies on the secondary data especially which
were collected from online sources. It is found that there are some initiatives in
the USA that can be adopted by Indonesia for improving its medical malpractice
system, especially the establishment of pretrial screening panel. It is expected that
pretrial screening process can eliminate meritless claims which later may reduce
unnecessary legal actions against doctors.

Keywords: Medical Malpractice; Medical Malpractice System; the USA; Indonesia.

Introduction
The growth of medical malpractice cases is a global phenomenon and countries are
trying to find ways to have amicable settlement. Alternative Dispute Resolution (ADR)
is one of solutions which obtains good acceptance worldwide. Following the successful
implementation of ADR in other countries, ADR methods especially mediation has
been adopted as a means to resolve medical malpractice disputes in Indonesia.2

1 Medical malpractice occurs in every country; Nelson MacNeil, ‘How Is Medical Malpractice
Different in the USA?’ (Medical malpractice occurs in every country) <https://www.nelsonmacneil.
com/blog/how-medical-malpractice-different-us/>.

2 By virtue of Section 29 of the Health Act 2009, mediation is mandatory for all disputes
involving healthcare professionals.
The adoption of ADR in Indonesia is still at its infancy and more efforts are needed to improve the working of ADR. Although ADR, especially mediation, has been made mandatory in the settlement of medical malpractice disputes since 2009, however its application encounters various obstacles, including the regulatory issue. It is useful to look at the best practice in different jurisdictions, especially in the USA. The reason to choose the USA in for the purpose of the comparative study is that because the USA has been successfully developed various methods of medical malpractice dispute settlement outside the court system.

**Medical Malpractice Phenomenon in the USA**

American society has been characterized as a litigious society. This has made the intensity of litigation process in the court of law so high in the United States as compared to other jurisdictions. The litigious nature of the American people has seriously affected the medical profession. According to Sonny Bal, medical malpractice lawsuits are a relatively common occurrence in the United States.³

The increase in medical malpractice litigation has caused the United States to suffer from the so-called medical malpractice crisis. Since the 1970’s, the USA has experienced three medical malpractice crisis, periods characterized by significant increases in the premiums and contractions in the supply of malpractice insurance.⁴ This increase has been attributed to various factors, but doctors claim that one of the prime sources of this escalation is the initiation of ‘unfounded’ or frivolous lawsuits.⁵

Since the early 1970s, legislatures and courts have struggled to reform the law governing medical malpractice claims. Many of proposed reforms seek to promote economic efficiency through some specific cost-containment or damage-limitation

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³ B. Sonny Bal MD. MBA, ‘An Introduction to Medical Malpractice in the United States’ (2009) 467 Clinical Orthopaedics and Related Research.[339].
⁴ Ben C.J. van Velthoven and Peter W. van Wijck, *Medical Liability: Do Doctors Care?*,[3].
⁵ In an effort to curb this perceived medical malpractice crisis, the medical community has resorted to a multifaceted counterattack. Medical associations have sponsored legislation which penalizes the plaintiffs of unfounded suits and have organized countersuit funds for doctors who become the victims of such litigation. Also, a nonprofit organization was formed to develop public awareness and solutions for the problems of frivolous malpractice suits. Mary Jane Yardley, ‘Malicious Prosecution: A Doctor’s Need for Reassessment’ (1984) 60 Chicago Kent Law Review.
mechanism. Other proposals seek to deter the filing of ‘frivolous’ claims. Most of the proposals give no attention to the law’s role in protecting the dignity of the participants. Economic considerations command the reformers’ exclusive attention.6

Various solutions have been proposed to reform the tort system and thereby reduce the rippling effects of the malpractice crisis on the cost and delivery of health care. The impetus for tort reforms comes from the heavy costs of litigation to the U.S. health care system. According to several reliable statistics, the numbers are staggering: 10 percent of all U.S. annual expenditures for health care goes to medical liability and defensive medicine; annually, $32.6 billion is spent for professional liability claims and expenses for hospitals, long-term care facilities (LTCF), and doctor’s malpractice awards; while total annual allocation to legal industry is $246 billion/year.7

Further, medical malpractice litigation costs are growing 7.5% annually; 50 to 80 percent of payouts by self-insured hospitals, LTCFs, and medical malpractice insurance companies go directly to attorney’s fees, both defense and plaintiff, and their “administrative costs”; 25 percent goes to adjusted loss allocation expenses; of the amount awarded to the injured patient (plaintiff), 35 – 50% goes to plaintiff’s attorney as a contingency fee award; while tort reform in several states may keep some cases from entering the pipeline, for any case that does enter the pipeline more than 50% goes to the plaintiff’s and defendant’s attorney fees.8

In response to the malpractice crisis, majority of US states have adopted tort reform measures. The objective of these measures is to reduce the overall costs of medical liability. The extent and specifics of tort reform vary from state to state. Some reforms make it more costly or difficult to file tort cases, other reforms aim at a reduction of damage awards. The following list gives an overview of the tort reforms most commonly adopted:9

6 Frank M. McClellan, Medical Malpractice (Temple University Press 1994).[ix].
7 The statistics refer to 2006 AHA Hospital Statistics, 2004 on Hospital Professional Liability and Doctor Benchmark Analysis, 2004’s Aggregates & Averages, and Prince Waterhouse Coopers 2006. Perry Hookman, Medical Malpractice Expert Witnessing: Introductory Guide for Doctor and Medical Professionals (CRC Press 2008).[203].
8 ibid.
9 Ben C.J. van Velthoven and Peter W. van Wijck (n 4).[12].
1) Shorter statutes of limitation: limit the amount of time a patient has to file a malpractice claim after the occurrence or discovery of the injury.

2) Contingency fee reform: limits the amount of a damage award that a plaintiff’s attorney may take in a contingent fee arrangement.

3) Pretrial screening panels: review a malpractice case at an early stage and assess whether a claim has sufficient merit to proceed to trial.

4) Caps on damages: limit the amount of money that a plaintiff can take as an award. The cap may apply to non-economic damages (pain and suffering), total damages, or only punitive damages.

5) Joint-and-several liability reform: limits the financial liability of each individual, in cases involving more than one defendant, to the percentage fault of the individual.

6) Collateral source rule reform: eliminates the traditional rule that any compensation a plaintiff receives from other sources, such as health insurance, should not be deducted from the damage award.

7) Periodic payment: allows or requires insurers to pay out malpractice awards over a longer period of time, rather than in a lump sum.

Besides gaining popularity from the malpractice crisis phenomenon, the United States has also been frequently referred to as the patient safety issue. Medical error has been alleged as the more dangerous killer than traffic accident in the United States. This fact has made medical malpractice litigation as a common phenomenon which latter created social and economic problem in the United States. However, litigation system for malpractice cases contains several deficiencies which encourage the USA government to continue the tort reforms.

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10 The issue of patient safety arose in response to the fact about the huge number of incident taking place in the hospitals due to human error. Such incident (commonly referred to as adverse event) is actually preventable, especially when hospital’s staffs exercise due care when providing health care service. Patient safety became a global movement especially after the release of the IOM’s report in 1999.

11 Based on landmark report of the Institute of Medicine (IOM) 1999, medical error is responsible for the death of at least 44,000 patients in hospital every year.

12 The direct costs of the malpractice liability system are widely estimated to be on the order of $20-$30 billion per year, while the indirect costs (principally defensive medicine) costs $100-$300 billion per year. David A. Hayman and Charles Silver, ‘Medical Malpractice and Global Perspective: How Does the USA Do It’ (2012) 87 Chicago Kent Law Review.

13 Peter P. Budetti and Teresa M. Waters explained that the traditional reliance on state courts to shape medical malpractice law started to change in the latest three decades of 20th century. As premiums for malpractice insurance climbed sharply, organized medicine began to put pressure on state legislatures to change many of the rules governing malpractice lawsuits that had been created by judges over the previous two centuries. State legislatures have responded to a number of issues concerning the malpractice tort claims system and passed statutes that changed a number of different aspects of malpractice law, some of which had dramatic effects. Those statutes are often referred to as “tort reforms”. More recently, the United States Congress has also considered legislation that would make federal laws more prominent in medical malpractice cases and would override at least some aspects of state laws. Peter P. Budetti and Tereza M. Winters, ‘Medical Malpractice Law in United States’ (2005).
While traditional malpractice reform efforts could reduce the number and success of malpractice lawsuits in some states, they do little to help patients injured by doctor negligence obtain what research suggests they truly desire: (1) an account of why the harm occurred; (2) an apology from the health care professionals involved; (3) information about how similar harms can be avoided in the future; and (4) appropriate restitution for an avoidable harm.\textsuperscript{14}

A 2013 study estimated that between 210,000 to 400,000 people die annually in the USA due to medical error. Ethically, a reformed medical malpractice system must address the fact that medical errors do injure patients and are at play in a significant number of malpractice cases. For example, Studdert and colleagues analyzed 1,452 closed malpractice claims from five liability insurers and concluded that 63 percent of the claims did, in fact, involve injuries due to medical error.\textsuperscript{15}

\textbf{Medical Malpractice System in the USA}

Medical malpractice law in the United States is derived from English common law, and was developed by rulings in various state courts. The legal system is to encourage extensive discovery and negotiations between adversarial parties with the goal of resolving dispute without going to jury trial. The injured patient must show that doctor acted negligently in rendering care, and that such negligence resulted in injury. To do so, four legal elements must be proven: (1) a professional duty owed to the patient; (2) breach of such duty; (3) injury caused by the breach; and (4) resulting damage. Many damages, if awarded, typically take into account both actual economic loss and non-economic loss, such as pain and suffering.\textsuperscript{16}

\textsuperscript{14} Joseph S. Kass and Rachel V. Rose, ‘Medical Malpractice Reform: Historical Approaches, Alternative Models, and Communication and Resolution Programs’ (2016) 18 American Medical Association Journal of Ethics.

\textsuperscript{15} ibid.[303].

\textsuperscript{16} B. Sonny Bal MD. MBA (n 3).[339]. Further discussion pertaining to the nature of the USA Legal System,Bureau of International Information Programs United States Department of State, ‘Outline of the USA Legal System’ (2004). It is written at page 12, “Where no statute or constitutional provision controls, both federal and state courts often look to the common law, a collection of judicial decisions, customs, and general principles that began centuries ago in England and continues to develop today.” See also Stephen W. Heath, \textit{Risk Management and Medical Liability} (Indian Health Service 2006).
Medical malpractice law in this country traditionally has been under the authority of the states, not the federal government. Unlike many other areas of the law, the framework and legal rules governing malpractice actions were, prior to the last thirty years, largely established through decisions in lawsuits in state courts rather than through statutes enacted by state legislatures. Legal rules established by the courts generally are referred to as ‘common law’. As the legal precedents that established the case law in one state have no weight in any other state, the rules for handling medical malpractice cases varied from state to state, although many of the principles were similar.\(^\text{17}\)

Dissatisfied patients in the USA have two primary means of complaining. They can contact the relevant state’s licensing board, which may revoke or limit the licenses of doctors found to have acted improperly; or sue the mentioned doctors when they can find lawyers willing to represent them. The utility of the first mechanism varies greatly from state to state–some are much more likely to initiate disciplinary proceedings against individual doctors than others–but speaking generally it seems that only the most egregious cases are likely to interest state medical boards. In relation to the second option, it is almost impossible to secure a recovery without help from a plaintiffs’ lawyer when liability is contested. According to David A. Hayman, obtaining counsel is harder than one might imagine. Because plaintiffs’ lawyers work on contingency, they screen cases carefully and decline most requests for representation.\(^\text{18}\)

Tort litigation system has been criticized for being inefficient, unfair, and costly to both patients, health care providers and to health care system. In order to

\(^{17}\) Medical malpractice law in the United States traces its roots back to 19\(^{th}\) Century English common law. The law that developed concerning medical malpractice is part of the more general body of law dealing with injuries to people or property, known as “tort law”. Medical malpractice cases are an example of one particular type of tort, known as “negligence”. The concept of negligence is that people should be reasonably careful in what they do, and, if they are not, they should be held responsible for the injuries that can be reasonably foreseen as resulting from their negligent conduct. See Peter P. Budetti and Tereza M. Winters (n 13).[2].

\(^{18}\) One study found that a plaintiffs’ law firm declined twenty-nine of thirty requests for representation, a 97 percent rejection rate, and also paid independent doctor-experts to review the cases it took. Once cases are accepted, plaintiffs’ lawyers research claims extensively using compulsory process, and they frequently drop cases when new information creates doubt about the merits. See David A. Hayman and Charles Silver (n 12).[171].
overcome problems associated with the tort litigation system, several methods have been suggested as an alternative to the existing tort litigation system in the USA.\textsuperscript{19}

**The USA of Alternative to Litigation to Deal with Medical Malpractice Disputes**

Alternative Dispute Resolution

US courts have encouraged parties in medical malpractice disputes to use various forms of Alternative Dispute Resolution (ADR) systems in an effort to produce cheaper and faster settlements.\textsuperscript{20} There are states that run a very successful program into ADR as an alternative to medical malpractice litigation including Wisconsin. Colorado and other states are trying to get into this position to decrease the load on the courts.\textsuperscript{21}

Alternative dispute resolution (ADR) models, which allow doctors and the health systems in which they operate to acknowledge openly when errors have occurred and offer reasonable compensation to the injured parties, balance the needs of clinicians to act ethically by being truthful and engaging in vigorous quality improvement and of patients to receive compensation for negligence-induced iatrogenic harm. Alternative dispute resolution allows litigants to move out of a “battle” mentality and into a facilitated conversation to achieve resolution of the conflict.\textsuperscript{22}

Discussion on the USAe of ADR for resolving the medical malpractice disputes will be limited only on several ADR methods especially arbitration and mediation.

a. Arbitration

Arbitration is the reference of a dispute for determination by a third party, arbitrator, whose decision will be based on the facts of the case and the evidence submitted by the parties, in which the parties agree to abide by a decision known often as award. The presentation of evidence, however, is in an informal basis.

\begin{itemize}
  \item \textsuperscript{19} World Bank, ‘Medical Malpractice Systems around the Globe: Examples from the USA-Tort Liability System and the Sweden-No Fault System’ (2003).
  \item \textsuperscript{20} John Farrar, *Legal Reasoning* (Thomson Reuters 2010),[85]. See also Williams, *Should the State Provide ADR Services* (CJQ 1987),[142].
  \item \textsuperscript{21} Perry Hookman (n 7).[201].
  \item \textsuperscript{22} Joseph S. Kass and Rachel V. Rose (n 14).[303].
\end{itemize}
Arbitration, being a private procedure, the parties do not run the risk of any damaging publicity which sometimes arises out of reports of court proceedings. Arbitration proceedings are less formal than court proceedings, with no need for technical rules of evidence and procedures used by the courts, generally less costly and less time consuming. Parties have the power of deciding the time and place to conduct the proceedings.23

In the United States, arbitration has been applied in medical malpractice cases for more than twenty years, making it the oldest and most common form of the three alternative processes. Arbitration in cases of medical disputes is mandated by statute in the state of Michigan and by contract in the state of California in the United States.24 However, arbitration has been criticized for becoming a legalized and operating institution of the law. This brings arbitration short of some of its potential ideas such as flexibility, informality and efficiency.25 In addition, arbitration shares similar characteristics with litigation, such as handing down of awards to plaintiffs if the arbitrator considers that the plaintiff has proved his case, following prescribed procedures which make it in a way formal and the parties may agree to the application of the rules of evidence.26

b. Mediation

Prior to 1960, mediation was a part of the dispute resolution landscape in the United States, but its use was not widespread. However, during the 1960’s and the 1970’s, with the development of the trial process and with an abundance of litigations taking place (so much so it was referred as the “litigation explosion”), courts and legislators, desperate to deal with this, began mediation programs in domestic relations cases and small claims cases. Thus, mediation grew from a small

23 Laurenca Boulle and Kathleen J. Kelly, Mediation: Principles, Process, and Practice (Butterworths 1998).[78].
24 John J. Fraser Jr, ‘Technical Report: Alternative Dispute Resolution in Medical Malpractice’ (2001) 107 Pediatrics. at 604. See also Perry Hookman (n 7).[205].
25 Arbitration has a close interaction with the court system because the parties are able to obtain court orders to assist the arbitration and to secure the court involvement in enforcing the arbitral awards. See Laurenca Boulle and Kathleen J. Kelly (n 23).[78].
26 David Spencer and Tom Altobelli, Dispute Resolution in Australia: Cases, Commentary and Materials (Lawbook Co 2005).[227].
practice taking over several civil areas and sometimes even criminal areas.\textsuperscript{27} Mediation has been defined as a process by which the participants, together with the assistance of a neutral person or persons, systematically isolate disputed issues in order to develop options, consider alternatives, and reach a consensual settlement that will accommodate their needs.\textsuperscript{28} In fact, there is diversity on the practice of mediation. Laurence Boulle and Miryana Nesic addressed the four distinguished models of mediation consisting of facilitative, evaluative, settlement and therapeutic or transformative as follows:\textsuperscript{29}

The facilitative model, sometimes referred to as 'pure mediation' or the 'classic mediation process' is the oldest type of mediation, where the mediator plays a neutral role in aiding the parties reach a solution that is agreeable to both parties while helping parties analyze the issues, explore favorable options and offer advice and opinions regarding the outcome where it is necessary. The mediator plays a referee role in controlling an otherwise hostile situation.\textsuperscript{30}

The evaluative mediation is hybrid form of mediation and arbitration, where the mediator performs a quasi-arbitral function by identifying the weakness of the arguments of both parties and even making predictions of the reactions of a judge or jury. The main difference between both types is that the latter is more focused on the legal aspect of the parties than on the personal interests and needs.\textsuperscript{31}

Settlement mediation occurs in court or other institutional settings which control and limit both what processes will be used and the possible outcomes. In such mediation, the setting is the key on how mediation can be conducted and with greater rigidity. While transformative mediation, also referred to as therapeutic mediation, seeks, on a number of different levels, to change either the dispute or the

\textsuperscript{27} Richard Birke quoted by David Spencer and Michael Brogan, \textit{Mediation Law and Practice} (Cambridge University Press 2006).[25-27].
\textsuperscript{28} Jay Folberg and Alison Taylor, \textit{Mediation: A Comprehensive Guide to Resolving Conflict without Litigation} (Jossey-Bass Publishers 1984).[7].
\textsuperscript{29} Laurence Boulle and Miryana Nesic, \textit{Mediation: Principles, Process, and Practice} (Butterworths 2001).[27-29].
\textsuperscript{30} ibid.
\textsuperscript{31} ibid.
disputants for instance by altering their appraisal of each other and their place in the world, by using professional therapeutic techniques and a decision will not be reached until the relationship between the disputants have been dealt with.\footnote{ibid.}

Despite these different models of mediation processes, mediation in general has been known to be effective in medical malpractice cases where the parties want to preserve their relationship or where lack of communications had led to the dispute.\footnote{John J. Fraser Jr (n 24).[603].} As highlighted by Florence Yee, mediation helps preserve the doctor-patient relationship of the parties. The possibility of such a relationship surviving has a slim chance in the holistic forum of litigation. When medical negligence occurs, patients usually want three things; the error’s cause, an apology from the doctor or hospital and an assurance that the mistake will not occur again and it may also have the possible effect of deterring future negligence on the part of the doctors.\footnote{Florence Yee, ‘Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis’ (2006) 7 Cardozo Journal of Conflict Resolution.}

John J. Fraser Jr. mentions that the advantages of mediation are lesser costs, confidential proceedings and the degree of control enjoyed by the disputing parties over the process and the outcomes. Mediation can be favorable for the injured parties, because it is a forum where they can express their concerns and may lead to an acknowledgment of problem, sometimes in the form of an apology.\footnote{John J. Fraser Jr (n 24).[603-604].} While Florence Yee advocates that mediation can avoid soaring costs associated with litigation such as lawyer fees and other expenses. In addition, where the transactional costs of processing the dispute through the legal system exceeds the amount in the dispute, parties benefit more from mediation which is less costly.\footnote{Florence Yee (n 34).[418].}

Several states have also mandated mediation in medical malpractice cases, the most recent one being Connecticut, where as of July 1, 2010, judges have to refer medical malpractice cases to a 120-day mediation period or any other alternative dispute resolution process before the close of proceedings.\footnote{‘Connecticut Mandates Mediation for Medical Malpractice Cases’.
The state of Wisconsin has a Mandatory Mediation Panel System (MMPS) which comprises of a lawyer who is the chair of the panel, a doctor or other health care professional with experience on the subject matter of the claim and a public member. Claimants could file claims for medical negligence 15 days before commencing the proceedings and mediations had to be completed within 90 days. The panel is aimed to facilitate the settlement by identifying strengths and weaknesses in each party’s position and by discussing alternative options. The panel makes no binding recommendations or decisions. In addition, several medical universities have also adopted formal medical malpractice programs, such as Philadelphia’s Drexel University College of Medicine, the University of Pittsburg Medical Center (UPMC) and the University of Michigan Health System.

A federal legislation was introduced in the USA House of Representatives in an effort to encourage mediation and reduce litigation costs, to fund mediation programs addressing medical malpractice claims. The “Comprehensive Medical Malpractice Reform Act 2005” is to fund mediation programs (through grants administered by the USA Department of Justice).

Carol B. Liebman and Chris Stern Hyman highlighted the ability of mediation especially the facilitative one to address fundamental issues underlying medical malpractice claims including the need of communication. Referring to several surveys, there are number of reasons why people make claims in medical malpractice cases. One of the reasons is pertaining to the inability of the doctors and hospitals to communicate with the victim or the victim’s family concerning the act of error or negligence for fear of their words being used in court later on, whereas on the other hand, claimants will resort to litigation in the need for answer. According to them, money is not all that the claimants desire; it could be answers and it could be a word of apology. Hence compensation or awards may not be the most satisfactory

38 Laurence Boulle and Miryana Nesic (n 29).[296].
39 Lee A. Rosengard and Marissa Parker, ‘Committing to Mediation: Enriched Resolution of Medical Malpractice Actions for Patients, Doctors and Insurance Companies’ (2009).
40 Nafiza Ali, ‘Facilitative Mediation in Resolving Medical Negligence Disputes’, the 4th APMF Conference held in Kuala Lumpur on 16 – 18 June (2008).
outcome for either party, since communication is an important aspect of the medical relationship between the medical practitioner and his or her patient.\textsuperscript{41}

In relation to this, Carol B. Liebman explained that in the past decade, the United States healthcare system has begun to use mediation to facilitate communication between patients and doctors after an adverse medical event, to ease tensions among members of care-giving teams, to resolve medical malpractice claims, and to help family members and medical professionals make awesome and wrenching decisions at the end of life. Implementation of the Patient Protection and Affordable Care Act of 2010 will produce new controversies and increase the need for mediation. Patients, families, doctors, nurses, other healthcare professionals, and administrators will require help managing the disagreements that arise as they adapt to the altered healthcare system.\textsuperscript{42}

c. Communication and Resolution Program (CRP)

Alternative dispute resolution especially mediation and arbitration can be quite effective in resolving disputes in a less adversarial and less costly manner than traditional litigation. A number of health care institutions have experimented with a unique twist on ADR by developing communication and resolution programs (CRPs), novel approaches to addressing medical error that have paid off in terms of the costs associated with malpractice litigation. These programs encourage open communication and transparency with patients and their families and facilitate restitution for injured parties when appropriate. They also support doctors in disclosure conversations with patients.\textsuperscript{43}

The Lexington Veterans Affairs (VA) Medical Center was a pioneer in this area. In 1987, the Lexington VA implemented its CRP, which provided a full

\textsuperscript{41} Such a communication can generally be achieved via mediation, especially facilitative mediation with the mediator’s role kept to a minimum. This is because arbitration and evaluative mediation have too much resemblance to the litigation process whereas the facilitative mediation is considerably different in nature. See Carol B. Liebman and Chris Stern Hyman in William M. Sage & Roger Kersh, \textit{Medical Malpractice and the USA Health Care System} (Cambridge University Press 2006). \textsuperscript{[191-216]}

\textsuperscript{42} Carol B. Liebman, ‘Medical Malpractice Mediation, Benefits Gained, Opportunities Lost’ (2011) 74 Law and Contemporary Problem.\textsuperscript{[135]}.  

\textsuperscript{43} Joseph S. Kass and Rachel V. Rose (n 14).\textsuperscript{[303]}
disclosure of the occurrence that led to harm as well as an expression of regret on behalf of the institution and its personnel. Under this system, patients and their families are invited to bring attorneys to discuss offers of compensation early in the process.\textsuperscript{44}

CRPs also exist outside the VA system and come in two varieties: early settlement and limited reimbursement. The University of Michigan Health System (UMHS) was the first non-VA health system to adopt a CRP, implementing an early settlement model in 2001. UMHS self-insures; all its doctors are employed and insured by the university rather than by commercial malpractice carriers, thereby simplifying buy-in to the CRP. This model has four components: (1) acknowledging when patients are injured due to medical error; (2) compensating fairly (commensurate with degree of harm) and quickly when there is a deviation from the standard of care; (3) aggressively defending against meritless cases; and (4) studying all adverse events to determine how health care delivery can be improved. As the payments are made on behalf of the institution only, they are not reported to the National Practitioner Data Bank (NPDB). This operational detail is significant because the NPDB, which was created by Congress, “contains information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers, and suppliers”. It is publically available information that may affect a doctor’s reputation and follows a doctor throughout his or her career.\textsuperscript{45}

\textsuperscript{44} Although ADR in a health care situation likely provides a number of benefits to both the health care provider (by promoting honesty and ethical behavior) and to the patient and patient’s family (by providing an honest accounting of what happened, including a statement of regret and possibly an offer of compensation), the empirical literature discussing ADR typically emphasizes quantitative, economic measures in the form of payouts as a measure of success. With the implementation of this program, the Lexington VA became the VA hospital with the lowest payouts. Between 1990 and 1996, the average settlement per claim in Lexington was approximately $15,622, whereas in other VA institutions it was $98,000. Additionally, the average duration of cases decreased from 2-4 years to 2-4 months. See ibid.

\textsuperscript{45} By not reporting this information to the NPDB, UMHS reduces an important barrier to doctor participation in this CRP; ibid.
No-Fault Compensation Scheme

After the discussion on the USAe of ADR methods, it is also important to look at the position of the no-fault liability system in the USA. It seems that this system is not adopted in the USA. In this respect, David A. Hyman and Charles Silver explains that no-fault liability for medical error has proven far more popular with academics than with legislators. Further, there are only a few pockets of strict liability for medical malpractice in the United States. Qualifying birth injury cases in Virginia and Florida are excluded from the tort system, and are handled through an administrative system. Ironically, plaintiffs with strong cases prefer to litigate in the tort system, since they can recover a greater amount, while plaintiffs with weak cases prefer the no-fault system. Products liability cases involving medical devices also qualify for strict liability treatment.46

The issue of no-fault compensation is not popular in Indonesia. Although some countries have adopted the scheme in medical injury cases for several decades, most of people in Indonesia are still unfamiliar with the scheme. The scheme is good in the sense that it may save the injured patients from the hurdle in proving medical errors. This may answer the issue of the patient’s lack of access to relevant evidences. However, it seems to be too idealistic for the current situation in Indonesia when financial resources still become an issue. Similar to the USA, this scheme is good for academic discourse but remains inapplicable in practice.

Conclusion

Various innovations have been made in the United States of America which are beneficial for Indonesia to learn, especially pretrial screening process. There is a need to establish a panel to run such a process. The existence of pretrial screening panel will settle the question on the merit of medical malpractice cases. The clarity on the merit of medical malpractice claim may reduce frivolous action from the patient and protect doctors from unnecessary legal action on medical malpractice.

46 David A. Hayman and Charles Silver (n 12).[17].
Medical disciplinary tribunal can be employed as a pretrial screening panel rather than to establish a new institution to run pretrial screening process.

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