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## Alternatives for the Disposition of Medical Malpractice Claims Student Symposium - A Study of Medical Malpractice in Texas.

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## ALTERNATIVES FOR THE DISPOSITION OF MEDICAL MALPRACTICE CLAIMS

In an effort to correct the failure of the present fault system to expeditiously deal with the growing number of medical malpractice claims, several states have implemented, and others are considering, various types of supplementary and alternative measures to litigation.<sup>295</sup> Criticism of the present system is voiced by every faction involved with the disposition of malpractice suits. Claimants complain of the difficulty in securing expert witnesses to support their claims, while physicians complain of the expense in defending against claims, the majority of which may be without merit.<sup>296</sup> The reputation of a physician may be damaged by the institution of a malpractice claim against him,<sup>297</sup> and no one involved in the action benefits from the extreme delay between the institution of a malpractice suit and its final disposition.<sup>298</sup> Some critics believe the jury and perhaps the judiciary may lack the capability required to deal with highly specialized fact situa-

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295. For detailed statistical data on the rising malpractice claims and projections for the future, see AMA, *MALPRACTICE IN FOCUS: A NATIONAL PROBLEM THE STATES MUST SOLVE*, at 12-13 (1975); and HEW, *MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE*, Pub. No. (OS) 73-88, at 5 (1973) [hereinafter referred to as *MALPRACTICE COMMISSION REPORT*].

Within the last year Florida, Illinois, Indiana, Massachusetts, Nevada, New York, and Wisconsin have legislatively implemented various forms of joint screening panels composed of both physicians and lawyers. These provisions follow the example set by New Hampshire which passed a statute providing for joint screening panels in 1972. Arkansas and Ohio have passed legislation providing for compulsory nonbinding arbitration while Louisiana, Michigan, and Tennessee have created provisions for binding arbitration by agreement between the health care provider and the patient. See Miike, *State Legislatures Address the Medical Malpractice Situation*, *J. LEGAL MED.*, Vol. 8, No. 3, Sept. 1975, at 25.

This year Senators Daniel Inouye and Edward Kennedy have introduced a bill into the United States Senate entitled the National Medical Injury Compensation Insurance Act which provides for a form of elective no-fault insurance. Inouye, 'A Federal no-fault malpractice law? Yes!', *PHYSICIAN'S MANAGEMENT*, Vol. 15, No. 10, Oct. 1975, at 46, 48.

296. *MALPRACTICE COMMISSION REPORT*, at 10 (1973).

297. See Inouye, 'A Federal no-fault malpractice law? Yes!', *PHYSICIAN'S MANAGEMENT*, Vol. 15, No. 10, Oct. 1975, at 46, 48. The Secretary's Commission on Medical Malpractice did not verify any material professional harm to a physician involved in a malpractice suit. It states that "[t]he medical profession is likely to coalesce around a colleague unjustifiably sued: and a doctor may even get sympathy from old and new patients who feel he is being unjustifiably prosecuted." Baird, Munsterman, & Stevens, *Alternatives to Litigation, I: Technical Analysis*, *MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, APPENDIX*, Pub. No. (OS) 73-89, at 214, 281 (1973) [hereinafter cited as *MALPRACTICE COMMISSION REPORT, APP.*].

298. The Malpractice Commission determined that many malpractice claims take four to five years to resolve. *MALPRACTICE COMMISSION REPORT*, at 89 (1973).

tions so often occurring in malpractice cases,<sup>299</sup> and it has been found that the present medical malpractice liability insurance system returns a lower portion of the premium dollar to the injured patient than any other form of casualty insurance.<sup>300</sup> The greatest impact, however, is on the public which, because of its ignorance of medical procedures and total dependence on the medical delivery system, has complained the least about the overwhelming economic burden it carries. In addition to the impact of national inflation on medical costs, the consumer must also absorb the growing costs of defensive medicine<sup>301</sup> and physicians' liability insurance.

The current malpractice crisis necessitates an evaluation of the major supplementary and alternative methods to the present litigation system, and requires that an attempt be made to identify the method which would conceivably solve the majority of the problems encountered in the disposition of medical malpractice claims. There are three major methods: screening panels, arbitration, and no-fault insurance coverage.

#### SCREENING PANELS

Screening panels have been instituted in various forms throughout the United States primarily to reduce the number of meritless malpractice suits filed. Panels create an informal forum whereby the expense, publicity, and difficulty of formal court proceedings are eliminated, and in which an expeditious determination may be made of whether or not the claim has merit. The main objective of screening panels is to encourage settlement by a physician or his insurer without resorting to litigation.<sup>302</sup> Since the proceedings of a panel are informal, the strict courtroom rules of evidence and procedure are not used.<sup>303</sup> The panel's findings of fact and determina-

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299. See Hassard & Cartwright, *Change Tort System? Lawyers Debate Its Value in Malpractice Disputes*, MED. WORLD NEWS, Vol. 16, No. 19, Sept. 8, 1975, at 60-61; Documentary Supplement, *Medical-Legal Screening Panels as an Alternative Approach to Medical Malpractice Claims*, 13 WM. & MARY L. REV. 695, 710 (1972).

300. Reynolds, *Malpractice: Is No-fault Compensation the Answer?*, MED. ECONOMICS, July 9, 1973, at 29, 30. It has been estimated that physicians and hospitals pay more than \$1 billion annually to insurance companies, but only \$160 million ever reaches the injured patients. Inouye, *'A Federal no-fault malpractice law? Yes!'*, PHYSICIAN'S MANAGEMENT, Vol. 15, No. 10, Oct. 1975, at 46-47. It has also been estimated that plaintiffs receive approximately 15% of the premium dollar for malpractice coverage. Insurance companies and defense counsel consume 55% in overhead and claims processing, and the balance, 30%, goes to the plaintiff's lawyer for fees. Carlson, *A Conceptualization of a No-fault Compensation System for Medical Injuries*, 7 LAW & SOC. REV. 329, 336 (1973).

301. See generally A. HOLDER, *MEDICAL MALPRACTICE LAW* 414-15 (1975); Bernzweig, *Defensive Medicine*, MALPRACTICE COMMISSION REPORT, APP., at 38-40 (1973).

302. MALPRACTICE COMMISSION REPORT, at 91 (1973).

303. Fla. Laws 1975, ch. 75-9, § 5, at 11, *codified in* FLA. STAT. ANN. § 768.133(7) (Supp. 1975) ("strict adherence to the rules of procedure and evidence applicable in civil cases shall not be required").

tions of the issues presented are only advisory<sup>304</sup> and in no case does it make a final determination of the amount of damages.<sup>305</sup> Existing plans for screening panels may be classified as physician review panels, physician review and advisory panels, and medico-legal or joint screening panels.

#### *Physician Review Panels and Physician and Advisory Panels*

Physician review panels are created by the medical society of a state or regional area, or by a medical society in cooperation with a malpractice insurance carrier, and are composed entirely of physicians.<sup>306</sup> These panels are not intended to resolve issues of liability and do not even afford the claimant a hearing. A claim is presented to the panel by an attorney or an administrative employee of the medical society and the sole function of the panel is to advise the physician and his insurer whether to settle or defend against the claim.<sup>307</sup> Thus, these panels merely aid the physician in determining how to deal with a claim filed against him.<sup>308</sup>

Physician and advisory panels operate in the same manner and serve essentially the same purpose as physician review panels, however, they are not composed solely of physicians. For example, King County, Washington has a panel which in addition to physician members includes an attorney who represents the bar association, advises the panel on legal matters, but has no vote in panel decisions.<sup>309</sup> In Honolulu, Hawaii the panel is composed of nine physicians, one member of the clergy who votes in panel decisions, and an attorney who merely advises the panel on legal matters.<sup>310</sup>

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304. A. HOLDER, *MEDICAL MALPRACTICE LAW* 416 (1975).

305. The Wisconsin statute provides for a panel to determine the quantum of damages with the result binding on the parties if they stipulate such in writing, or if no appeal is taken within 120 days after the panel's determination. This provision is very similar to arbitration by agreement. Wis. Laws 1975, ch. 37, § 10, at 46-48, *codified in* Wis. STAT. § 655.16-20 (Supp. 1975). The New Hampshire statute also provides for the determination of damages by the panel and this determination is binding only if both parties accept the panel's decision. N.H. REV. STATS. ANN. ch. 519-A:5 (Supp. 1973).

306. Baird, Munsterman, & Stevens, *Alternatives to Litigation, I: Technical Analysis*, MALPRACTICE COMMISSION REPORT, APP., at 214, 224-25 (1973).

307. *Id.* at 225. See A. HOLDER, *MEDICAL MALPRACTICE LAW* 416 (1975); Lillard, *Arbitration of Medical Malpractice Claims*, 26 ARB. J. 193, 199 (1971).

308. Physician review panels currently exist in Idaho, Maine, Maryland, New Hampshire, Oregon, and Rhode Island. A. HOLDER, *MEDICAL MALPRACTICE LAW* 416 (1975). There is evidence that there are numerous others whose existence is not publicized. One study indicates that 11.1% of all medical malpractice claims are reviewed by such panels. Baird, Munsterman, & Stevens, *Alternatives to Litigation, I: Technical Analysis*, MALPRACTICE COMMISSION REPORT, APP., at 214, 225 n.5 (1973).

309. Baird, Munsterman, & Stevens, *Alternatives to Litigation, I: Technical Analysis*, MALPRACTICE COMMISSION REPORT, APP., at 214, 225 (1973).

310. *Id.* at 225, 280. A clergyman is both sensitive to the sentiments of the general public and usually has an educational background which enables him to deal with the complex issues reviewed by a panel. These qualities make him an excellent disinterested third party in disputes involving the legal and medical communities.

Like physician review panels, physician and advisory panels hear only the physician's side of the story and assist the physician in determining how to approach the claim filed against him.

Usually, if a physician defends against a claim at trial upon the recommendation of a panel, the claimant will not be awarded damages against the physician or his insurance company. If, however, the panel recommends out-of-court settlement, the insurance company has knowledge of the evidence against the insured physician and can settle accordingly.<sup>311</sup> These results could help stabilize the rising physician's malpractice insurance premiums by minimizing amounts spent by insurance companies on settlements. Because physician review panels and physician and advisory panels do not determine issues of negligence, they offer no final solution to the disposition of medical malpractice claims. These panels, however, could be used beneficially in connection with any claims disposition method to help clarify for the defendant his position in the case.

#### *Medico-Legal or Joint Screening Panels*

The majority of screening panels established thus far have been panels composed of voting members of both the medical and the legal professions. The composition of a panel may vary from as few as three to as many as 10 persons representing the bar and 10 persons representing the medical profession.<sup>312</sup> Joint screening panels have been created by an agreement between a state or regional medical society and a corresponding bar association,<sup>313</sup> by court rule,<sup>314</sup> and by statute.<sup>315</sup> The majority of the statutory panels have been created within the last six months, and many of these statutes were enacted in states which already had screening panels created

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311. See Panel Discussion, *Are Malpractice Screening Panels the Answer?*, MED. ECONOMICS, March 1, 1971, at 106, 136. These observations presuppose the accuracy of panel determinations.

312. See, e.g., Fla. Laws 1975, ch. 75-9, § 5, at 10, *codified in* FLA. STAT. ANN. § 768.122(1) (Supp. 1975); Mass. Laws 1975, ch. 362, § 5, at 321; A. HOLDER, MEDICAL MALPRACTICE LAW 417 (1975).

313. The Secretary's Commission on Medical Malpractice found such panels to exist in Alaska, Arizona, Colorado, Delaware, Florida, Idaho, Iowa, Maine, Montana, Nevada, New Mexico, New York, Ohio, Pennsylvania, Virginia, Washington, and Wisconsin. Baird, Munsterman, & Stevens, *Alternatives to Litigation, I: Technical Analysis*, MALPRACTICE COMMISSION REPORT, APP., at 280-81 (1973).

314. The state of New Jersey and two counties in New York State have established joint screening panels by court rule. A. HOLDER, MEDICAL MALPRACTICE LAW 420 (1975).

315. Fla. Laws 1975, ch. 75-9, § 5, at 10, *codified in* FLA. STAT. ANN. § 768.133 (Supp. 1975); Ind. Laws 1975, Pub. L. No. 146, § 1, art. 9.5, ch. 9, § 1, at 864, *codified in* IND. ANN. STATS. § 16-9.5-9-1 (Supp. 1975); Mass. Laws 1975, ch. 362, § 5, at 321; Nev. Laws 1975, ch. 302, §§ 1-12, at 409-11; N.H. REV. STATS. ANN. §§ 519-A:1 to 519-A:10 (Supp. 1973); 29 N.Y. JUDICIARY LAWS § 148-a (McKinney Supp. 1974); Wis. Laws 1975, ch. 37, § 10, at 42-48, *codified in* WIS. STAT. § 655.02-655.21 (Supp. 1975).

by either medical society-bar association agreement or court rule.<sup>316</sup> Where this overlap occurs, the statutory panels will probably replace the antecedent agreement and court adopted panels because of the superior jurisdictional aspects of a joint screening panel created by statute.

Joint panels created by medical society-bar association agreement have jurisdiction over only those members of that particular medical society,<sup>317</sup> whereas statutory panels have jurisdiction over all medical personnel as well as medical related industries. Almost 50 percent of the cases that go to trial involve more than one defendant.<sup>318</sup> Frequently, one of these co-defendants is a hospital, pharmaceutical company, manufacturer of medical devices, or health care provider over whom the medical society has no control or jurisdiction. There may be reluctance on the part of these co-defendants to voluntarily appear before a panel which has no member who represents that defendant's specialty or health care field. This limits the usefulness of screening panels created by medical society-bar association agreements because there is difficulty in joining the parties within one action before the panel. Most statutory panels cure this problem by allowing multiple defendants to select a panelist to represent all their interests, or, in the case of one specialist or non-physician defendant, allowing a representative of the same specialty or health care field to sit on the panel.<sup>319</sup> Some statutes specifically provide for joinder of the parties.<sup>320</sup>

The jurisdiction of a screening panel created by medical society-bar association agreement or by court rule may only be invoked voluntarily by a claimant. Under no plan created by agreement or court rule, may a claimant be compelled to submit his allegations to the scrutiny of a panel.<sup>321</sup> Most statutes creating joint screening panels, however, require that *all* malpractice claims be submitted to the appropriate screening panel.<sup>322</sup> The

316. Florida, Nevada, and Wisconsin have enacted statutes subsequent to panels created by agreement. New York had an antecedent panel system adopted by court rule.

317. A. HOLDER, *MEDICAL MALPRACTICE LAW* 418 (1975).

318. *MALPRACTICE COMMISSION REPORT*, at 91 (1973).

319. See Ind. Laws 1975, Pub. L. No. 146, § 1, art. 9.5, ch. 9, § 3(c), at 864, *codified in* IND. ANN. STATS. § 16-9.5-9-3(c) (Supp. 1975) (allowing multiple plaintiffs or defendants to select one physician to sit on panel); Mass. Laws 1975, ch. 362, § 5, at 322 (where action is against non-physician health care provider, physician's position on panel shall be replaced with representative of that field of medicine in which the tort occurred).

320. Wis. Laws 1975, ch. 37, § 10, at 45-46, *codified in* WIS. STAT. § 655.10 (Supp. 1975) (panel may order that any additional claimant or respondent be joined when it deems inclusion of such party necessary and proper to a just determination of the claim).

321. A. HOLDER, *MEDICAL MALPRACTICE LAW* 416 (1975).

322. The Florida, Indiana, Massachusetts, and Nevada statutes require that every malpractice claim be heard by a screening panel. Indiana and Nevada require further that no cause of action may be filed in court before an opinion of a screening panel has been rendered. Fla. Laws 1975, ch. 75-9, § 5, at 10, *codified in* FLA. STAT. ANN. § 768.111(1) (Supp. 1975); Ind. Laws 1975, Pub. L. No. 146, § 1, art. 9.5, ch. 9, §§ 1-2 at

only impetus for a claimant to present his claim voluntarily to a joint screening panel is that if the panel determines that the claim has merit, the panel will provide expert witnesses to testify in support of the claimant at any subsequent trial.<sup>323</sup> This provision for expert witnesses virtually eliminates the claimant's problem with the "conspiracy of silence" within the medical community,<sup>324</sup> and has been incorporated into at least one statutory plan.<sup>325</sup> The compulsory nature of statutory joint screening panels and the incorporation of many of the provisions found in panels created by medical society-bar association agreement and court rule renders ineffective those panels created by agreement and court rule in those states with statutory panels.

These jurisdictional aspects make statutory joint screening panels vastly superior to panels created by medical society-bar association agreement or court rule; therefore, the remainder of this section will be concerned primarily with joint screening panels created by statute.

The composition of the statutory joint screening panel varies from a tribunal to as many as three persons representing the medical community and three persons representing the legal community.<sup>326</sup> A tribunal consists of a medical representative from the same specialty or health field as the defendant and any two of the following: an attorney, a judge, or a member

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864, *codified in* IND. ANN. STATS. § 16-9.5-9-3(c) (Supp. 1975); Mass. Laws 1975, ch. 362, § 5, at 321; Nev. Laws 1975, ch. 302, §§ 6, 8, at 410; *see* N.H. REV. STATS. ANN. § 519-A:2 (Supp. 1973) (allowing voluntary submission of claim to panel).

323. Expert witnesses are usually provided for in the terms of an agreement, whereby the claimant agrees to submit his claim to a screening panel in exchange for the names of expert witnesses if his claim is found to have merit. A. HOLDER, *MEDICAL MALPRACTICE LAW* 417 (1975).

324. Peer presence on the panel and the realization by the medical community that each claim has been found by the panel to entail great possibility of negligence, should alleviate the reluctance on the part of an expert witness to testify against his fellow professional. *See* Averbach, *Rx for Malpractice*, 19 CLEV. ST. L. REV. 20, 29 (1970).

325. Nev. Laws 1975, ch. 302, § 11, at 411.

326. *See* Fla. Laws 1975, ch. 75-9, § 5, at 10, *codified in* FLA. STAT. ANN. § 768.133(1) (Supp. 1975) (providing for circuit judge to be presiding member of panel, including a licensed physician and attorney); Ind. Laws 1975, Pub. L. No. 146, § 1, art. 9.5, ch. 9, § 3, at 864, *codified in* IND. ANN. STATS. § 16-9.5-9-3(c) (Supp. 1975) (providing for one attorney who acts only as advisor and three physicians); Mass. Laws 1975, ch. 362, § 5, at 321 (providing for a justice of the superior court, a licensed physician and an attorney authorized to practice in Massachusetts); Nev. Laws, ch. 302, § 4, at 410 (providing for three members of legal profession and three members of medical profession); N.H. REV. STATS. ANN. ch. 519-A:2 (Supp. 1973) (providing for panel to consist of a state court judge, one person representing the public, and one person of the same health care field as the defendant); N.Y. JUDICIARY LAWS § 148-a(2)d (McKinney Supp. 1975) (providing for a tribunal composed of a justice of the New York Supreme Court, a physician, and an attorney); Wis. Laws 1975, ch. 37, § 10, at 42-43, *codified in* WIS. STAT. § 655.03(2)(a)(2) (Supp. 1975) (providing for a tribunal, in informal panels, consisting of one attorney to act as chairman, one health care professional of the same specialty, and one member of the public selected from list of petit jurors).

of the general public.<sup>327</sup> Usually, both the claimant and the defendant exercise some control in the selection of these members.<sup>328</sup> Such a collection of professionals and experts is more qualified to make determinations on liability than a jury, and in addition is more likely to distinguish meritorious from nonmeritorious claims.<sup>329</sup> With such a composition these panels, unlike a jury, are less likely to be swayed in their deliberations by emotional factors such as disfiguring facial scars or a claim for astronomical damages for pain and suffering.

Most recently passed statutes provide for the mandatory submission of claims to a panel which are initiated in much the same manner as in a court proceeding.<sup>330</sup> The proceedings of statutory joint screening panels are usually informal with relaxed rules of evidence and procedure used in court actions.<sup>331</sup> Some panels are allowed to adopt their own procedural rules<sup>332</sup> while others rely on a state appellate court to create their procedural

327. Fla. Laws 1975, ch. 75-9, § 5, at 10, *codified in* FLA. STAT. ANN. § 768.133(1) (Supp. 1975); Mass. Laws 1975, ch. 362, § 5, at 321; 29 N.Y. JUDICIARY LAWS § 148-a(2) (McKinney Supp. 1975); Wis. Laws 1975, ch. 39, § 10, at 42-43, *as codified* Wis. STAT. § 655.03(2) (Supp. 1975).

328. Each party is entitled to strike the names of each type of panel member from a given list or to choose members to represent them. See Ind. Laws 1975, Pub. L. No. 146, § 1, art. 9.5, ch. 9, § 3(b), at 864, *codified in* IND. ANN. STAT. § 16-9.5-9-3(c) (Supp. 1975) (permitting each party to select one physician); Wis. Laws 1975, ch. 37, § 10, at 43, *codified in* Wis. STAT. § 655.03(2)(c) (Supp. 1975) (allowing each party to strike one name from each of three categories of panel members).

329. Comment, *Medical-Legal Screening Panels as an Alternative Approach to Medical Malpractice Claims*, 13 WM. & MARY L. REV. 693, 722 (1972).

330. See Fla. Laws 1975, ch. 75-9, § 5, at 10, *codified in* FLA. STAT. ANN. § 768.133(1) (panels are to facilitate the position of all malpractice actions); Ind. Laws 1975, Pub. L. No. 146, § 1, art. 9.5, ch. 9, § 2 at 864, *codified in* IND. ANN. STAT. § 16-9.5-9-2 (Supp. 1975) (no action may be commenced in any court before the complaint has been presented to a medical review panel). See also Mass. Laws 1975, ch. 362, § 5, at 321; Nev. Laws 1975, ch. 302, § 6, at 410. The Wisconsin statute provides that any patient may file a submission of controversy. Wis. Laws 1975, ch. 37, § 10, at 43, *codified in* Wis. STAT. § 655.04(1)(a) (Supp. 1975) (emphasis added). Florida's statute allows an escape from the mandatory review by a panel "if no answer [by the defendant(s)] is filed within such time limit [20 days of the date of service], the jurisdiction of the mediation panel over the subject matter shall terminate, and the parties may proceed in accordance with law." Fla. Laws 1975, ch. 75-9, § 5, at 11, *codified in* FLA. STAT. ANN. § 768.133(2) (Supp. 1975).

331. Fla. Laws 1975, ch. 75-9, § 5, at 11, *codified in* FLA. STAT. ANN. § 768.133(7) (Supp. 1975). Wisconsin in addition to its informal panels, has a provision for a formal panel which follows that state's rules of civil procedure. Findings of the informal panels are inadmissible in subsequent court action, while findings of the formal panels are admissible. The claimant is heard by an informal panel when the claim is for \$10,000 or less. If the claim is over \$10,000 then a formal panel has jurisdiction. A claimant heard by either panel is never precluded from appeal. Wis. Laws 1975, ch. 37, § 10, at 42-48, *codified in* Wis. STAT. §§ 655.03-655.19 (Supp. 1975).

332. Nev. Laws 1975, ch. 302, § 5, at 410; Wis. Laws 1975, ch. 37, § 10, at 44, *codified in* Wis. STAT. § 655.04(4)(b) (Supp. 1975).



rules.<sup>333</sup> These rules, however, are never as strict or detailed as statutory rules used by the courts.

Evidence considered by statutory panels is primarily written material and may include such things as textbooks, treatises, and "any other form" permitted by the panel.<sup>334</sup> Witnesses may either give oral testimony or may be heard by depositions.<sup>335</sup> In most instances witnesses and evidence may be subpoenaed by either party for presentation to the panel.<sup>336</sup> Most statutes creating panels do not require transcripts of the proceedings to be made;<sup>337</sup> those which permit transcripts allow their use primarily by the medical community or state.<sup>338</sup> This use of transcripts is for quality control purposes, that is, the medical societies must know what has been held to be medical malpractice in order that preventive measures may be taken. This limited use of transcripts assures the privacy of the panel's proceedings and thus a defendant avoids any stigma attached to having a claim brought against him.

All of the statutory joint screening panels deliberate the issue of liability which is determined by whether or not there is substantial evidence that the acts or omissions complained of constitute negligence on the part of the defendant and whether or not the negligence, if any, actually injured the claimant.<sup>339</sup> A few panels also make determinations on the amount of actual damages.<sup>340</sup> Such a determination of damages provides a more rational basis for settlement than if the parties were to negotiate between

333. Fla. Laws 1975, ch. 75-9, § 5, at 11, 29 *codified in* FLA. STAT. ANN. § 768.133 (7) (Supp. 1975); N.Y. JUDICIARY LAWS § 148-a(1) (McKinney Supp. 1975).

334. Ind. Laws 1975, Pub. L. No. 146, § 1, art 9.5, ch. 9, § 4 at 865, *codified in* IND. ANN. STATS. § 16-9.5-9-4 (Supp. 1975).

335. Fla. Laws 1975, ch. 75-9, § 5, at 11, *codified in* FLA. STAT. ANN. § 768.133(7) (Supp. 1975); Ind. Laws 1975, Pub. L. No. 146, § 1, art. 9.5, ch. 9, § 4, at 865-66, *codified in* IND. ANN. STATS. § 16-9.5-9-4 (Supp. 1975); Mass. Laws 1975, ch. 362, § 5, at 322.

336. Fla. Laws 1975, ch. 75-9, § 5, at 12, *codified in* FLA. STAT. ANN. § 768.133(7) (Supp. 1975); Mass. Laws 1975, ch. 362, § 5, at 322.

337. Fla. Laws 1975, ch. 75-9, § 5, at 12, *codified in* FLA. STAT. ANN. § 768.133(7) (Supp. 1975) (allowing either party to have the proceedings transcribed); 29 N.Y. JUDICIARY LAWS § 148-a(4) (McKinney Supp. 1975); Wis. Laws 1975, ch. 37, § 10, at 47, *codified in* WIS. STAT. § 655.18(1) (Supp. 1975) (informal panels are without stenographic record).

338. *See* Nev. Laws 1975, ch. 302, § 11(2) at 411; Wis. Laws 1975, ch. 37, § 10, at 47, *codified in* WIS. STAT. § 655.17(3) (Supp. 1975) (panel reports are not available to the public, unless in the opinion of the panel, public interest so requires).

339. *See* Nev. Laws 1975, ch. 302, § 7, at 410; Mass. Laws 1975, ch. 362, § 5, at 321; Note, *The New Mexico Medico-Legal Malpractice Panel—An Analysis*, 3 N.M.L. REV. 311, 319 (1973) (dealing with panels created by agreement between the medical society and the bar association).

340. Fla. Laws 1975, ch. 75-9, § 5, at 12, *codified in* FLA. STAT. ANN. § 768.11(7) (Supp. 1975); N.H. REV. STATS. ANN. § 519-A:4 (Supp. 1973); Wis. Laws 1975, ch. 37, § 10, at 45, *codified in* WIS. STAT. § 655.065(2) (Supp. 1975); A. HOLDER, *MEDICAL MALPRACTICE LAW* 421-22 (1975) (discussing the New Hampshire statute).

themselves, and it should lead to settlement of a greater number of meritorious claims. Under all statutory plans, the parties are free to either abide by the panel's findings and settle, or look to the courts and litigation for a final determination of their rights and liabilities.<sup>341</sup> Only in New Hampshire and Wisconsin may the parties be bound when they agree in writing to abide by the panel's findings and recommendations.<sup>342</sup> This type of agreement is identical to arbitration agreements discussed in the next section.

Decisions of a statutory joint screening panel are usually made into a written report which in most states is admissible into evidence at any subsequent trial.<sup>343</sup> However, any findings as to the quantum of damages are never allowed in evidence at trial, presumably because the subsequent court action is a trial de novo of the claim.<sup>344</sup> Any report of the panel which is admitted into evidence is not binding on the jury but is ascribed the weight the jury deems appropriate.<sup>345</sup>

In addition to the panel reports, most statutory plans make expert witnesses available to the parties for any subsequent trial. These witnesses may be either experts who appeared before the panel or panel members themselves.<sup>346</sup> When a panel member is called to testify, his testimony may be limited to discussing the panel's recommendations;<sup>347</sup> or, he may discuss the merits of the case and be afforded general immunity from prosecution for any action taken or opinion given in his official capacity as a panel member.<sup>348</sup> Several statutes, however, prohibit any panelist to be involved in any manner with a subsequent trial.<sup>349</sup> It is believed that few persons

341. Fla. Laws 1975, ch. 75-9, § 5, at 12, *codified in* FLA. STAT. ANN. § 768.133(10) (Supp. 1975).

342. N.H. REV. STATS. ANN. § 519-A:5 (Supp. 1973); Wis. Laws 1975, ch. 37, § 10, at 45, *codified in* WIS. STAT. § 655.07 (Supp. 1975).

343. Fla. Laws 1975, ch. 75-9, § 5, at 12, *codified in* FLA. STAT. ANN. § 768.133 (Supp. 1975); Ind. Laws 1975, Pub. L. No. 146, § 1, art. 9.5, ch. 9, § 9, at 867, *codified in* IND. ANN. STAT. § 16-9.5-9-9 (Supp. 1975); Wis. Laws 1975, ch. 37, § 10, at 47-48, *codified in* WIS. STAT. § 655.19(1) (Supp. 1975) (findings of a formal panel are admissible while findings of an informal panel are not).

344. Fla. Laws 1975, ch. 75-9, § 5, at 12, *codified in* FLA. STAT. ANN. § 768.133 (Supp. 1975); N.H. REV. STATS. ANN. § 519-A:8 (Supp. 1973); Wis. Laws 1975, ch. 37, § 10, at 47, *codified in* WIS. STAT. § 655.19(1) (Supp. 1975).

345. *See* Fla. Laws 1975, ch. 75-9, § 5, at 12, *codified in* FLA. STAT. ANN. § 768.133(11) (Supp. 1975); N.Y. Laws 1975, ch. 109, § 16, at 139.

346. Mass. Laws 1975, ch. 362, § 5, at 322-23; N.Y. Laws 1975, ch. 109, § 15, at 138 (holding that special witnesses appearing before the panel may be called by either party at subsequent trial as a witness); *see* Ind. Laws 1975, Pub. L. No. 146, § 1, art. 9.5, ch. 9, § 9, at 867, *codified in* IND. ANN. STAT. § 16-9.5-9-9 (Supp. 1975) (allowing either party to call any member of the review panel as a witness in any subsequent trial).

347. *See* N.Y. Laws 1975, ch. 109, § 16, at 139.

348. *See* Ind. Laws 1975, Pub. L. No. 146, § 1, art. 9.5, ch. 9, § 9, at 867, *codified in* IND. ANN. STAT. § 16-9.5-9-9 (Supp. 1975).

349. *See* Fla. Laws 1975, ch. 75-9, § 5, at 12, *codified in* FLA. STAT. ANN. § 768.133(11) (Supp. 1975); N.Y. Laws 1975, ch. 109, § 13, at 138 (prohibiting the justice presiding over panel from presiding at any subsequent trial and prohibiting

would want to serve on a joint screening panel if they were subject to subpoena in a subsequent trial of the case.<sup>350</sup> The general availability of panel reports and expert witnesses alleviates one of the trial attorney's greatest obstacles—the problem of introducing medical evidence at the trial.<sup>351</sup> It should be noted here that the primary purpose of joint screening panels is to allow an equitable settlement rather than to provide evidence for court proceedings.

If settlement is not reached and the case is taken to court, Massachusetts has required the claimant to post a \$2,000 bond to defray the defendant's court costs and attorney's fees in the event the claimant loses.<sup>352</sup> Upon motion by the claimant and a determination by the court that the claimant is indigent, the court may reduce the amount of the bond but may never totally eliminate it.<sup>353</sup> With a similar goal in mind, Wisconsin allows the court to award court costs and reasonable attorney's fees to the prevailing party.<sup>354</sup> Both of these measures further reduce the chance of the filing of a nonmeritorious suit as well as easing, for the physician who prevails, the economic burden of defending against a claim.

Statutory joint screening panels solve many of the problems now encountered in the litigation of medical malpractice claims. The difficulty in securing expert witnesses by a claimant is virtually eliminated and the expense of the total proceeding is drastically reduced. The privacy of screening panel proceedings minimize any damage to a defendant physician's reputation, and he may continue to be an effective health care provider. The claim is disposed of quickly unlike the present system which often requires years of proceedings. To enhance the speedy disposition of claims, most statutes creating panels establish time limits in which to file an answer to the claim, choose the panelists, and appeal to the courts.<sup>355</sup> Screening panels consisting of experts are able to deal with the specialized fact situations much more easily than a jury, and the emphasis on settlement should return a greater portion of the insurance premium dollar to those claimants with meritorious claims. The money currently expended on insurance and legal overhead may be diverted directly to the injured claimant, and because frivolous claims will not be settled and will not go to trial, the insurance

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physician and attorney members of panel to participate as counsel for either party at trial); Wis. Laws 1975, ch. 37, § 10, at 47, *codified in* Wis. STAT. § 655.19 (Supp. 1975).

350. A. HOLDER, *MEDICAL MALPRACTICE LAW* 417 (1975).

351. See Averbach, *Rx for Malpractice*, 19 CLEV. ST. L. REV. 20, 29 (1970).

352. Mass. Laws 1975, ch. 362, § 5; at 323.

353. *Id.*

354. Wis. Laws 1975, ch. 37, § 10, at 47, *codified in* Wis. STAT. § 655.19(1) (Supp. 1975).

355. Fla. Laws 1975, ch. 75-9, § 5, at 11, *codified in* FLA. STAT. ANN. § 768.133(2) (Supp. 1975) (giving defendant(s) 20 days to file an answer; allowing 10 days for parties to agree on panelists before court clerk compiles lists of potential panelists at random; and allowing 60 days to effect an appeal to the circuit courts).

companies will not have to underwrite defense costs of nonmeritorious suits. This should help stabilize insurance rates for the physicians and in turn should alleviate the economic burden on the consumer. All of these attributes make statutory joint screening panels one of the more viable alternatives to the present system of disposing of medical malpractice claims.

#### ARBITRATION

Arbitration is a final and binding settlement of disputes and is designed as a substitute for court proceedings.<sup>356</sup> It is, however, generally recognized that arbitration is supplementary to, rather than pre-emptive of, the jurisdiction of the courts.<sup>357</sup> Like joint screening panels, the advantages of arbitration over litigation include speedier disposition, less expense, greater privacy, less rigid rules of evidence, practical expertise, and a reduction of the emotional element which tends to influence juries.<sup>358</sup>

Generally, arbitration boards are selected by two methods. First, each party selects an arbitrator who in turn agree on neutral arbitrators,<sup>359</sup> or, as one statute provides, neutral arbitrators are appointed by the court.<sup>360</sup> Second, identical lists of potential arbitrators are given to each party who then indicate preferences and objections to those on the list. The lists are subsequently compared and arbitrators are chosen who are acceptable to both parties.<sup>361</sup> These arbitration boards proceed in much the same manner as joint screening panels and consider the merits of the case. Arbitration boards determine legal liability, either in tort or in contract,<sup>362</sup> and additionally determine the amount of damages to which a claimant is entitled. The basic difference between arbitration and joint screening panels is that in most jurisdictions arbitration findings are final, binding, and enforceable by the courts.<sup>363</sup> Arbitration awards may be filed with a court

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356. Note, *Arbitration of Medical Liability*, 211 J.A.M.A. 175 (1970).

357. Adams & Bell, *Alternatives to Litigation, II: Constitutionality of Arbitration Statutes*, MALPRACTICE COMMISSION REPORT, APP., at 315, 317 (1973).

358. See MALPRACTICE COMMISSION REPORT, at 94 (1973); A. HOLDER, *MEDICAL MALPRACTICE LAW 423* (1975); Henderson, *Arbitration and Medical Services: Securing the Promise to Arbitrate Malpractice*, 28 ARB. J. 14, 33 (1973).

359. See La. Laws 1975, Act No. 371, § 1, ch. 2, § 4233, at 652 (allowing claimant to choose equal number of arbitrators as health care provider; chosen arbitrators then select one or more neutral arbitrators); A. HOLDER, *MEDICAL MALPRACTICE LAW 424* (1975).

360. Ohio Laws 1975, HB 682, § 2711.21(A), at 4-163.

361. A. HOLDER, *MEDICAL MALPRACTICE LAW 424* (1975).

362. Contractual liability for express warranties is a growing area of concern and only the Wisconsin joint screening panel statute allows for the panel to hear contract cases. Wis. Laws 1975, ch. 37, § 10, at 43, *codified in* Wis. STAT. § 655.04 (Supp. 1975). Texas has recently precluded contractual liability unless the contract is in writing, signed by both parties, and notarized.

363. See Wadlington, *Alternatives to Litigation, IV: The Law of Arbitration in the U.S.*, MALPRACTICE COMMISSION REPORT, APP., at 346, 348 (1973) (stating that arbitration awards are final and binding in 47 of the 51 jurisdictions studied).

for entry of judgment and if that judgment is not voluntarily paid, the plaintiff may levy on the defendant's property for the payment of the award.<sup>364</sup>

Arbitration is initiated by agreement between the parties which creates the binding characteristic of the process based on contract. Agreement of the parties may be reached before medical service is rendered and thus before a cause of action arises, or after a dispute occurs.<sup>365</sup> Agreements to arbitrate disputes arising in the future are enforceable only if they are specifically authorized by statute.<sup>366</sup> Such statutory sanction is required because of the common law view that an agreement to settle future disputes by arbitration is contrary to public policy as an attempt to deprive the courts of their jurisdiction.<sup>367</sup> Like commercial arbitration statutes, the statutes providing for the arbitration of medical malpractice disputes overturn this common law view by declaring that written agreements to arbitrate any dispute, whether existing or prospective, are "valid, enforceable, and irrevocable."<sup>368</sup> Statutes passed thus far providing for binding arbitration by agreement do not require compulsory submission of a claim to an arbitration board;<sup>369</sup> Ohio's statute, however, provides for compulsory nonbinding arbitration.<sup>370</sup> This latter type of statute is virtually identical to statutes creating joint screening panels.

Provisions to arbitrate future disputes have been incorporated in pre-paid health-care plans, the oldest of which is the Roos-Loos Medical Group in Los Angeles, and admission forms which are signed by a patient when he enters the hospital.<sup>371</sup> Another plan to increase arbitration of medical

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364. A. HOLDER, *MEDICAL MALPRACTICE LAW* 424(1975).

365. Henderson, *Arbitration and Medical Services: Securing the Promise to Arbitrate Malpractice*, 28 *ARB. J.* 14, 15-16 (1973); Henderson, *Alternatives to Litigation, III: Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice*, *MALPRACTICE COMMISSION REPORT, APP.*, at 321, 322 (1973).

366. A. HOLDER, *MEDICAL MALPRACTICE LAW* 422 (1975).

367. For example, Texas has held that a provision in an executory contract requiring any disputes arising out of the contract to be settled by binding arbitration is against public policy in attempting to oust the courts of their jurisdiction. *International Bhd. of Elect. Workers v. Whitley*, 278 S.W.2d 560, 563 (Tex. Civ. App.—Waco 1955, writ ref'd n.r.e.). However, mere agreements to arbitrate disputes, not to be consummated by award, do not oust the courts of their jurisdiction. *Id.* at 562.

368. La. Laws 1975, Act No. 371, § 1, ch. 2, § 4232, at 651; Ohio Laws 1975, HB 682, § 2711.22, at 4-163. See also Mich. Laws 1975, Pub. Act. No. 140, ch. 10A, 3, §§ 27A.5041(7), 27A.5042(8), at 669-70 (presuming the validity of an arbitration agreement which includes the provisions of this section).

369. See, e.g., La. Laws 1975, Act. No. 371, § 51, ch. 2, §§ 4230-4236, at 650-52 (allowing for voluntary arbitration agreements).

370. Ohio Laws 1975, HB 682, § 2711.21, at 4-163 (stating that upon the filing of any medical claim the controversy shall be submitted to an arbitration board).

371. The Ross-Loos Medical Group for 40 years has included in its prepaid health-care plan the following clause:

In the event of any controversy between the subscribing group and the subscriber or dependent, or the heirs at law or personal representative of the subscriber or de-

disputes initiated by the insurance industry requires that the insured physician secure arbitration agreements from a specified percentage of his patients.<sup>372</sup> These plans, as well as the statutory provisions for arbitration of medical malpractice disputes present simple methods of attaining arbitration agreements between health care providers and patients.<sup>373</sup>

The legality of agreements to arbitrate future disputes under the Ross-Loos Medical Group plan has been tested by the Supreme Court of California. In *Doyle v. Giuliucci*<sup>374</sup> the court held that an agreement to arbitrate restricts no constitutional rights because such an agreement "does no more than specify a forum for the settlement of disputes."<sup>375</sup> This short phrase firmly establishes a person's right to pursue disposition of a claim in a forum other than the constitutionally protected right to trial. Agreements to arbitrate, however, limit the right of appeal, and it is generally believed that such a limitation leads to the denial of rights.<sup>376</sup> The California Supreme Court stated that the "issue of arbitrability and the award are subject to judicial review."<sup>377</sup> It was held that a court may vacate the arbitrators' award only if certain restricted circumstances set out by statute occurred.<sup>378</sup>

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pendent, as the case may be, and Ross-Loos, when involving a claim in tort, contract or otherwise, the same shall be settled by arbitration.

Lillard, *Arbitration of Medical Malpractice Claims*, 26 ARB. J. 193, 197-98 (1971). For an in-depth discussion and a case-by-case analysis of the Ross-Loos Medical Group, see Rubsamen, *The Experience of Binding Arbitration in the Ross-Loos Medical Group*, MALPRACTICE COMMISSION REPORT, APP., at 424 (1973).

Since 1969, a group of hospitals in southern California, in cooperation with the California Medical Association, the California Hospital Association, and the American Arbitration Association have included in their admissions form the following arbitration clause:

*Arbitration Option:* Any legal claim or civil action in connection with this hospitalization, by or against hospital or its employees or any doctor of medicine agreeing in writing to be bound by this provision, shall be settled by arbitration at the option of any party bound by this provision, in accordance with the Commercial Arbitration Rules of the American Arbitration Association and with the Hospital Arbitration Regulations of the California Hospital Association (copies available on request at the hospital admission office), unless patient or undersigned initials below or sends a written communication to the contrary to the hospital within thirty (30) days of the date of patient discharge.

If patient, or undersigned, does not agree to the "Arbitration Option," then he will initial here. \_\_\_\_\_

Bergen, *Medical Arbitration Experiments*, 211 J.A.M.A. 351, 352 (1970).

372. This plan was initiated by the Casualty Indemnity Exchange Company, and is entitled "C.I.E. Plan III." Henderson, *Arbitration and Medical Services: Securing the Promise to Arbitrate Malpractice*, 28 ARB. J. 14, 17 (1973).

373. Only Louisiana, Michigan, and Ohio have thus far passed statutes especially providing for the arbitration of medical malpractice disputes. La. Laws 1975, Act. No. 371, § 1, at 650-52; Mich. Laws 1975, Pub. Act. No. 140, cl. 50A, § 3, at 668; Ohio Laws 1975, HB 682, at 4-160.

374. 43 Cal. Rptr. 697 (1965).

375. *Id.* at 699.

376. See Rubsamen, *The Experience of Binding Arbitration in the Ross-Loos Medical Group*, MALPRACTICE COMMISSION REPORT, APP., at 424, 426 (1973).

377. *Doyle v. Giuliucci*, 43 Cal. Rptr. 697, 699 (1965).

378. For California's statutory circumstances see Rubsamen, *The Experience of*

This extremely limited right of appeal makes arbitration efficient and allows for a finality in the disposition of medical malpractice claims. It should be noted that compulsory arbitration by statute without right of appeal would undoubtedly be held unconstitutional.<sup>379</sup>

Because of its contractual basis, arbitration is subject to the various conditions and problems inherent in contract law. Like other contractual rights, the right to arbitrate under agreement can be lost through failure to assert that right.<sup>380</sup> Major problems concern the capacity of the patient to contract, failure to reach an agreement, informed consent, and disparity in bargaining power of adhesion questions. The capacity of a patient to contract is of primary importance when he is bargaining away his constitutional right to trial. Resolution of this problem is particularly required in agreements involving minors and the mentally incompetent.

The power of a parent to bind a minor by an arbitration agreement and the minor's power to later disaffirm the agreement, arise frequently in contracts for medical care. The California Supreme Court addressed this problem by holding that a dependent infant was bound by an arbitration provision in a health care contract executed by his parent.<sup>381</sup> It is reasoned that since minors may disaffirm their own contracts under California law, health-care providers will tend to contract exclusively with adults. Therefore, parents must possess the authority to contract for their dependent minors if the minors are to be "assured of the benefits of group medical services."<sup>382</sup> If minors were able to disaffirm arbitration agreements executed by their parents, it is speculated that health care providers would use only non-arbitral systems for the disposition of medical malpractice claims, and as a result, minors would be denied the benefits of arbitration.<sup>383</sup>

There has been no case, however, of an adult attempting to disaffirm an arbitration contract to which he was a party while still a minor.<sup>384</sup> In anticipating the issue, Michigan statutorily binds a minor to a written arbitration agreement by his parent and forbids subsequent disaffirmance.<sup>385</sup> Other states would have to similarly respond to this issue by adopting laws

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*Binding Arbitration in the Ross-Loos Medical Group*, MALPRACTICE COMMISSION REPORT, APP., at 424, 426 n.6 (1973).

379. A. HOLDER, *MEDICAL MALPRACTICE LAW* 424 (1975).

380. See *Gunderson v. County of Los Angeles*, 120 Cal. Rptr. 35, 38 (Ct. App. 1975).

381. *Doyle v. Giuliucci*, 43 Cal. Rptr. 697, 699 (1965).

382. *Id.* at 699. For a general discussion see Henderson, *Alternatives to Litigation, III: Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice*, MALPRACTICE COMMISSION REPORT, APP., at 321, 326-27 (1973).

383. See Henderson, *Arbitration and Medical Services: Securing the Promise to Arbitrate Malpractice*, 28 ARB. J. 14, 19 (1973), citing *Doyle v. Giuliucci*, 43 Cal. Rptr. 697, 699 (Cal. 1965).

384. A. HOLDER, *MEDICAL MALPRACTICE LAW* 429 (1975).

385. Mich. Laws 1975, Pub. Act. No. 140, ch. 50A, § 3, § 27A.5046(2), at 673.

severely restricting or eliminating the power of a minor to disaffirm arbitration agreements after reaching majority. Recent statutes and court decisions, such as the *Doyle* case, clearly show a trend toward the restriction of a minor's right of disaffirmance and a rising attitude of favor toward the use of arbitration as a forum for reconciling malpractice disputes.

Mental incompetency constitutes a ground for avoidance of any contract in two situations: first, where a person is incapable of understanding the nature and the consequences of the contract, and second, where a person is incapable of reasonable action in relation to the transaction of the contract.<sup>386</sup> In both of these instances the other party must have knowledge of the person's limitations and incapacities before avoidance may be effective. A party attempting to avoid an arbitration contract on grounds of incompetency rarely is able to provide adverse consequences rising from the arbitration clause. Pecuniary losses are non-existent and there is no tangible pecuniary impetus for a person to litigate a claim rather than submit it to arbitration. Court annulment of the contract does nothing to return the parties to a status quo because a claim must still be heard and resolved in another forum. Consequently, even on a small scale, avoidance of arbitration contracts is very unlikely on these grounds.<sup>387</sup>

Since arbitration is enforceable only if there is a valid contract, there must be an actual agreement or meeting of the minds of the parties. If a party desires to avoid an arbitration contract this could be a major point of attack by asserting that he did not intend to agree to an arbitration clause or that he was unaware of its existence in the contract.<sup>388</sup> This attack was recently leveled at an arbitration clause in a state's group health plan by a California state employee. A California appellate court responded by holding that a state employee was bound by the state retirement system's agreement to arbitrate all medical malpractice claims, even though the employee did not know of the agreement and would not have consented to it.<sup>389</sup> The presupposition of a valid contract for the enforcement of arbitration brings into focus an additional problem of the patient's informed consent to arbitration. Given the number of malpractice suits dealing with the absence of informed consent to various medical procedures performed on patients, the addition of a clause for arbitration could conceivably bring a large number of suits in which plaintiffs allege they did not give informed consent to arbitration.<sup>390</sup> As a result, attempts to institute arbitration agreements

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386. RESTATEMENT (SECOND) OF CONTRACTS § 18C (Tent. Draft Nos. 1-7, 1973).

387. See Henderson, *Arbitration and Medical Services: Securing the Promise to Arbitrate Malpractice*, 28 ARB. J. 14, 22 (1973).

388. *Id.* at 22.

389. *Madden v. Kaiser Foundation Hosps.*, 123 Cal. Rptr. 696, 700-701 (Ct. App. 1975).

390. See A. HOLDER, *MEDICAL MALPRACTICE LAW* 427 (1975).



for future disputes may bring an increase in litigation examining the patient's informed consent to the arbitration clause.<sup>391</sup> The remedy to these problems lies in drafting arbitration provisions which are obvious on the face of the health care contract and understandable by a patient or easily explained with a minimum amount of legal background.

Another major concern is that an agreement between a patient and a physician to arbitrate medical malpractice claims poses quite a different situation than a contract between two equal parties. The physician has a superior bargaining position in that the patient must look to the medical system for health problems about which he knows nothing. Under the doctrine involving adhesion contracts, contracts may be avoided if the party with an inferior bargaining position has no alternative but to waive his legal rights.<sup>392</sup> This situation arises more frequently when a patient requires immediate medical attention and is asked to sign an agreement to arbitrate than where a person is entering a contract for future health care. Recent statutes have attempted to cure this disparity in bargaining power by requiring positions in the arbitration agreement stating that the agreement to arbitrate is *not* a prerequisite to medical treatment.<sup>393</sup> These statutes further provide two opportunities to escape an arbitration clause; revocation is allowed either when the agreement is initially made, or within a statutory time after the agreement is executed or treatment is given.<sup>394</sup> A patient's failure to avail himself of either of these opportunities would make it very difficult to convince a court that the agreement was an adhesion contract.

Arbitration is widely accepted throughout the country. There are 48 jurisdictions within the United States which now have general arbitration

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391. One authority states that:

It is perfectly ludicrous to assume that the average patient who signs an arbitration agreement on admission to a hospital understands its implications. There are too many decisions in which patients have recovered large amounts of damages because they signed surgical consents to "mastectomy" or "laminectomy" without understanding what those words meant to make any inference that the same patients would understand the word "arbitration." Furthermore, it is the author's firm conviction that very few physicians have any real grasp of all the legal implications of these clauses and any discussion between physician and patient on the subject could easily degenerate into the classic case of "the blind leading the blind."

*Id.* at 427.

392. *Id.* at 426.

393. Mich. Laws 1975, Pub. Act. No. 140, ch. 50A, § 3, §§ 27A.5041(2), 27A.5042(2), at 669-70; Ohio Laws 1975, HB 683, § 2711.23(A), at 4-163. A provision in an admissions form of a hospital stating that the patient would not sue the hospital or hold any employees liable for negligence was held unconstitutional. *Tunkl v. Regents of Univ. of Cal.*, 32 Cal. Rptr. 33, 36 (1963).

394. See, e.g., La. Laws 1975, Act No. 371, § 1, at 652 (allowing revocation of the agreement within 30 days of its execution); Mich. Laws 1975, Pub. Act. No. 140, ch. 50A, § 3, §§ 27A.5041(3), 27A.5042(3), at 699-70 (allowing revocation within 60 days of the agreement's execution); Ohio Laws 1975, H.B. 683, § 2711.23(B), at 4-163 (allowing 60 days for revocation). The hospital group in southern California has a similar provision in its arbitration option which is quoted in note 371 *supra*.

statutes.<sup>395</sup> Only three states, however, have specifically provided for the arbitration of medical malpractice claims,<sup>396</sup> even though a recent study shows that the majority of states could easily adopt such provisions.<sup>397</sup> Texas is among those states which would have little difficulty in extending its general arbitration statute to cover medical malpractice disputes.<sup>398</sup> Texas courts have held that settlement of disputes by arbitration is favored in Texas, and statutes relating to arbitration should be construed liberally in keeping with that principle.<sup>399</sup>

Any statutory provision passed by a state for the arbitration of medical malpractice disputes should empower the parties to agree to arbitrate disputes arising in the future and contain special words declaring the enforceability of such agreements. Although hasty use of untested arbitration is discouraged,<sup>400</sup> it is generally agreed that arbitration could provide uniform compensation for those injured patients with small claims that presently remain unsettled because the claimant is financially unable to pursue court action, or the amount of damage recoverable is too small to compensate a lawyer adequately under the contingency fee system.<sup>401</sup> It seems unlikely, however, that arbitration will provide a complete solution to the present problem.

#### NO-FAULT INSURANCE

Unlike the methods thus far discussed, there has not yet developed within the United States a functioning prototype of no-fault insurance in the area of medical malpractice. The only no-fault systems presently in use in the United States are in the areas of personal injury arising out of automobile collisions and injuries received in the course of employment covered by workmen's compensation plans. There are, however, two basic types of no-

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395. Wadlington, *Alternatives to Litigation, IV: The Law of Arbitration in the U.S.*, MALPRACTICE COMMISSION REPORT, APP., at 346, 347 (1973).

396. These states are Louisiana, Michigan and Ohio. La. Laws 1975, Act No. 371, § 1, at 650-52; Mich. Laws 1975, Pub. Act. No. 140, cl. 50A, § 3, at 668; Ohio Laws 1975, HB 682, at 4-160.

397. See Wadlington, *Alternatives to Litigation, IV: The Law of Arbitration in the U.S.*, MALPRACTICE COMMISSION REPORT, APP., at 346, 348-49 (1973).

398. TEX. REV. CIV. STAT. ANN. art. 224-249 (1973); see Wadlington, *Alternatives to Litigation, IV: The Law of Arbitration in the U.S.*, MALPRACTICE COMMISSION REPORT, APP., at 346, 412 (1973).

399. See *Carpenter v. North River Ins. Co.*, 436 S.W.2d 549, 553 (Tex. Civ. App.—Houston [14th Dist.] 1968, writ ref'd n.r.e.); *Knutson v. Brazoria County*, 170 S.W.2d 843 (Tex. Civ. App.—Galveston), *aff'd*, 142 Tex. 172, 178, 176 S.W.2d 740, 743 (1943).

400. Address by Richard E. Lerner, associate general counsel of the American Arbitration Association, American Bar Association annual meeting, Aug., 1975, *noted in TRUSTEE*, Vol. 28, No. 10, Oct. 1975, at 30.

401. Zimmerly, *Is Arbitration the Answer?*, J. LEGAL MED. Vol. 1, No. 1, March 1973, at 45.

fault plans for medical malpractice which have recently gained attention: a social insurance system, and variations of workmen's compensation-type system.

A social insurance system operates on governmental funding and is administered by governmental personnel. New Zealand recently implemented a social insurance system providing that any accidental injury from any cause entitles the victim to full compensation from the governmental fund, including all out-of-pocket expenses as well as economic reparation.<sup>402</sup> Under such a system there would exist no relationship between fault of the physician and compensation to the injured patient, which factors are inextricably bound under the present fault system. Money would be dispensed relative to the need for the benefits rather than to the cause of that need.<sup>403</sup> If social insurance were to be considered in the United States, its dependency on government funding, which in turn depends on public taxation, would make public acceptance unlikely.<sup>404</sup> In view of the cost estimates of similar yet more conservative proposals,<sup>405</sup> as well as the state of the national economy, it is very unlikely that a social insurance system would be implemented in the United States in the near future.

The typical proposal for no-fault coverage of medical related injuries is similar to a workmen's compensation system in which the injured relinquishes his right to sue in tort in exchange for immediate compensation, without regard to fault, for his out-of-pocket expenses.<sup>406</sup> Applying this system to medical injuries, compensation would be limited to out-of-pocket expenses, such as hospital bills and loss of income, which have not been covered by collateral sources such as health insurance or sick pay, and would never include nonpecuniary losses. There could be no compensation for such intangible damages as pain, suffering, or mental anguish primarily because it would be impossible to define them on a fixed payment scale set up by an actuarial board.

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402. A. HOLDER, *MEDICAL MALPRACTICE LAW* 431 (1975), citing Bernstein, "No-Fault" Compensation for Personal Injury in New Zealand, *MALPRACTICE COMMISSION REPORT, APP.*, at 836, 848 (1973). For an in-depth study and history of the New Zealand System, see Palmer & Lemons, *Toward the Disappearance of Tort Law—New Zealand's New Compensation Plan*, 1972 U. ILL. L.F. 693.

403. Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 603-604 (1973).

404. For an extensive discussion which rejects a social insurance system as a solution, see O'Connell, *Expanding No-Fault Beyond Auto Insurance*, 59 VA. L. REV. 749, 805-12 (1973).

405. The Social Security Administration estimated that President Nixon's 1971 national health insurance proposal would cause federal expenditures of approximately \$34 billion. It was also estimated that Senator Edward Kennedy's more liberal bill would require \$91 billion. See O'Connell, *No-Fault Insurance for Injuries Arising from Medical Treatments: A Proposal for Elective Coverage*, 24 EMORY L.J. 21, 28 (1975).

406. A. HOLDER, *MEDICAL MALPRACTICE LAW* 431 (1975).

No-fault insurance could be implemented in various ways, but whatever method is used, there remain serious problems. The obvious difficulty is how to standardize compensation for injuries, in light of the varying impact the same type injury may have on different people. For instance, the loss of a leg by a professional football player would be more damaging than the loss of a leg to a business executive who enjoys jogging but whose earning capacity remains unaffected. A clear solution would be to review each case individually by an administrative board, but this would escalate the costs of no-fault.

Most difficulties accompanying no-fault insurance for medical malpractice stem from practical problems of implementation. No-fault compensation should be based on the degree of the deviation of a given result from an expected result for a similar treatment.<sup>407</sup> Before the degree of deviation between the actual and expected results may be measured the exact cause of the deviation must be ascertained because the goal of a no-fault system is to compensate for those injuries caused only by the medical treatment. Problems arise in trying to assess what portion of the unexpected result is attributable to the medical treatment and not concomitant to the initial ailment which led the patient to seek medical help. This determination of causation would be simple if all medical injuries were caused by visible trauma, but resolution of this problem is rendered virtually impossible in view of the numerous, obscure, complex factors and the unique reactions and physical states of each patient. Social insurance cures this problem by totally eliminating cause as well as fault from consideration, while under a workmen's compensation type insurance system the cause of the deviation determines whether the injury falls under the definition of a compensable injury and thus within the scope of coverage.

The definition of a compensable injury to be covered by the no-fault insurance plan presents a major problem in itself. Unlike no-fault auto insurance, which simply covers accidents "arising out of the maintenance or use" of a motor vehicle,<sup>408</sup> no-fault insurance covering medical malpractice must define with certainty those injuries covered by the insurance, or face high administrative costs in determining in each instance if the injury was caused by the medical treatment and thus is within the scope of the coverage. The definition recommended to the Secretary's Commission on Medical Malpractice states that a medical injury is

any physical harm, bodily impairment, disfigurement, or delay in recovery which (i) is more probably associated in whole or in part with

407. Carlson, *A Conceptualization of No-Fault Compensation for Medical Injuries*, 7 LAW & SOC. REV. 329, 357 (1973).

408. Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 614 (1973), citing UNIFORM MOTOR VEHICLE ACCIDENT REPARATIONS ACT § 2 (enacted in Georgia and Hawaii); see GA. CODE ANN. 56-34106 (Supp. 1975); HAWAII REV. LAWS 294-1 (Supp. 1974).

medical intervention rather than with the condition for which such intervention occurred, and (ii) is not consistent with or reasonably to be expected as a consequence of such intervention or (iii) is a result of medical intervention to which the patient has not given his informed consent.<sup>409</sup>

This definition covers those injuries presently compensable under the tort system which are caused by treatment, and in addition includes all medical injuries relating to unavoidable accidents, known risk treatments, and untoward results. Because of the great expansion of the scope of injuries covered, application of this definition would greatly increase the number of claims filed for no-fault compensation. Further, this definition covers only iatrogenic or treatment-caused complications, and fails to allow for recovery against the physician who negligently overlooks a condition and therefore negligently fails to treat it.

One of the more feasible proposals for the implementation of no-fault insurance is to allow each medical practitioner to determine what injuries he desires to compensate on a no-fault basis. Termed "elective no-fault,"<sup>410</sup> this type of coverage could be implemented with or without an enabling statute.<sup>411</sup> With an enabling statute allowing substitution of no-fault for common law liability, the health care provider could, in a contract with his insurer, elect what classes of risks giving rise to injury will be compensable on a no-fault basis, leaving all other risks subject to present tort law.<sup>412</sup> Tort action by claimants suffering from injuries arising from risks which the physician elected to be covered by no-fault would be precluded.<sup>413</sup>

Such enabling legislation is the ultimate goal, but during the interim in the absence of an enabling statute, it is proposed that physicians and hospitals establish no-fault liability with their patients by agreement.<sup>414</sup> No-fault provisions could be written into hospital admission forms or could be offered

409. Roth & Rosenthal, *Non Fault Based Medical Injury Compensation Systems*, MALPRACTICE COMMISSION REPORT, APP., at 450, 460 (1973).

410. For a discussion of elective coverage by the major proponent, see O'Connell, *No-Fault Insurance for Injuries Arising From Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21, 34-42 (1975). Senators Inouye and Kennedy have recently introduced into the United States Senate an enabling provision for elective no-fault coverage. See Inouye, 'A Federal No-Fault Malpractice Law? Yes!', PHYSICIAN'S MANAGEMENT, Vol. 15, No. 10, Oct. 1975, at 46, 48.

411. O'Connell, *Elective No-Fault Liability by Contract—With or Without an Enabling Statute*, 1975 U. ILL. L.F. 59.

412. *Id.* at 62; O'Connell, *No-Fault Insurance for Injuries Arising From Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21, 41 (1975).

413. O'Connell, *No-Fault Insurance for Injuries Arising From Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21, 35 (1975); O'Connell, *Elective No-Fault Liability By Contract—With or Without an Enabling Statute*, 1975 U. ILL. L.F. 59, 62.

414. O'Connell, *Elective No-Fault Liability By Contract—With or Without an Enabling Statute*, 1975 U. ILL. L.F. 59, 65; O'Connell & Roddis, *Can No-Fault Malpractice Insurance Really Work?*, MED. WORLD NEWS, Vol. 16, No. 21, Oct. 6, 1975, at 98, 100.

by a physician when he obtains informed consent from the patient in much the same manner as arbitration agreements are now consummated.<sup>415</sup> This would essentially be a system of liability by contract, whereby the physician agrees to pay for injuries arising from chosen risks on a no-fault basis in exchange for the patient's agreement to accept no-fault payment and to forfeit any right of action in tort against the physician.<sup>416</sup> The primary impetus for a patient to agree to no-fault payments is that compensation would be immediate, without the delay under the present system, and these immediate payments would cover all of his out-of-pocket expenses.

Although a physician would have to compensate more persons under this system, it is believed that a physician would want to elect no-fault coverage because he would pay much less to each person. Payment would not be made for items covered by collateral sources, pain and suffering would not be compensable, and huge amounts would be saved in the defense against claims.<sup>417</sup> This proposal eases the difficulty in defining a medical injury because it allows each health care provider to determine what injuries will be covered by no-fault. There remains, however, the administrative problem of determining whether any given injury is caused by the medical treatment. Under such a proposal, because of the difficulty in accurately defining the scope of the coverage, it seems speculative that the volume of legal and factual disputes will be reduced.<sup>418</sup> The simple cases may be readily disposed of while the more complicated ones will be subject to legal maneuvering and argument. There is the likelihood that the defense lawyer will wish to allege that the particular injury lies within the scope of no-fault coverage, while the claimant's lawyer, if he believes greater compensation could be obtained in litigation, will assert it does not.<sup>419</sup> In addition, under an enabling statute allowing each health care provider to decide which risks will be covered by no-fault, patients of one physician, having no opportunity to decide, would be compensated on a no-fault, limited recovery basis while patients of physicians who did not elect no-fault would be compensated under the present tort system of full recovery for similar injuries arising from identical risks. Such a situation borders on invidious discrimination and certainly fails the due process and the equal protection provisions of the

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415. O'Connell, *Elective No-Fault Liability by Contract—With or Without an Enabling Statute*, 1975 U. ILL. L.F. 59, 65; O'Connell & Roddis, *Can No-Fault Malpractice Insurance Really Work?*, MED. WORLD NEWS, Vol. 16, No. 21, Oct. 6, 1975, at 98, 100.

416. O'Connell, *No-Fault Insurance For Injuries Arising From Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21, 41 (1975); O'Connell & Roddis, *Can No-Fault Malpractice Insurance Really Work?*, MED. WORLD NEWS, Vol. 16, No. 21, Oct. 6, 1975, at 98, 99.

417. O'Connell, *No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage*, 24 EMORY L.J. 21, 36 (1975).

418. O'Connell & Roddis, *Can No-Fault Malpractice Insurance Really Work?*, MED. WORLD NEWS, Vol. 16, No. 21, Oct. 6, 1975, at 98, 103.

419. *Id.* at 102-103.

Constitution. Thus the acceptability of elective no-fault, which would run concurrently with the present system is uncertain.

Conversion to a no-fault system would require a complete overhaul of the present tort system. It is generally agreed that no-fault eliminates issues of negligence and thereby the stigma attached to accusations of negligence, but it is argued that there is also eliminated the deterrent value of holding the legally culpable accountable for their negligent action or inaction.<sup>420</sup> Such accountability serves as incentive to medical care providers to exercise greater care in the delivery of medical treatment. This assumption, in theory, seems accurate but some critics feel that a deterrent for substandard conduct does not arise out of the fear of malpractice suits, and that the quality control of medicine is wholly disconnected from a practitioner's history of malpractice.<sup>421</sup> Further, not only is substandard conduct deterred by the present system, but also innovative treatments with potential for positive cures and medical advancements which far outweigh the risk of adverse effects to the patient.<sup>422</sup> Such innovative treatment is postponed for further study or is totally rejected because of the risks involved and the fear of a lawsuit upon its failure. It is believed that substitution of the present system with no-fault would therefore allow medical advancement, as well as enable development of a comprehensive data system to monitor claims experiences and provide for regulatory agencies' quality control information which is presently unavailable.<sup>423</sup>

Because of the vast number of additional claimants eligible for no-fault compensation, the many problems inherent in implementation, and the difficulty in predicting social impact, it is doubtful that a no-fault system could provide an immediate answer to the medical malpractice crisis. A long range solution may arise from no-fault, but the Secretary's Commission on Medical Malpractice did not believe that "we should leap headlong" into an untested no-fault system.<sup>424</sup> Thus, experimentation, with an eye to the future, is recommended.

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420. Lanzone, *No-Fault Medical Malpractice: Is This Really the Solution?*, TRIAL, Vol. 11, No. 3, May, 1975, at 46, 47.

421. Inouye, *A Federal No-Fault Malpractice Law? Yes!*, PHYSICIAN'S MANAGEMENT, Vol. 15, No. 10, Oct., 1975, at 46, 51, stating that "[g]ood doctors practice good medicine in spite of the malpractice threat, not because of it." Presently, grounds for professional discipline involve moral turpitude, not the history of the professional's malpractice. See Carlson, *A Conceptualization of a No-Fault Compensation System for Medical Injuries*, 7 LAW & SOC. REV. 329, 354, 364 (1973).

422. See Carlson, *A Conceptualization of a No-Fault Compensation System for Medical Injuries*, 7 LAW & SOC. REV. 329, 360-61 (1973); Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 599 (1973).

423. Carlson, *A Conceptualization of a No-Fault Compensation System for Medical Injuries*, 7 LAW & SOC. REV. 329, 365-68 (1973).

424. MALPRACTICE COMMISSION REPORT, at 101-102 (1973).

## CONCLUSION

During the last century, the number of binding jury verdicts against physicians in Texas may be expressed in two digits. Therefore, it is not the final monetary awards reached by litigation that has caused the malpractice crisis, it is the great expense of both time and money in reaching those awards which has been a major factor. Because of the costs of litigation, insurance companies often find it economically beneficial to settle out of court simply because it is cheaper to settle than to pursue disposition through litigation. Thus, many claims are settled, not on their merits, but rather on economic considerations. A system should be created whereby the costs of determining liability are minimized. In addition, a good system should be equitable to all involved, allow for prompt disposition and compensation, provide a forum to determine adequate compensation while minimizing the opportunity for unreasonable profit, create inducement for the medical community to correct substandard conduct, and provide a reliable, predictable process for determination of claims enabling the insurance industry to predict potential losses and to project funds needed and premium costs.

Each of the methods of malpractice claims disposition discussed has certain advantages as well as disadvantages. It is submitted that a statutory scheme combining the best qualities of compulsory joint screening panels with the binding aspect and limited right of appeal found in arbitration is the ideal solution to the current problems inherent in the litigation of medical malpractice claims. However, such a compulsory binding system would undoubtedly be held unconstitutional as denying the right to a jury trial. Therefore, it is expedient that a system be created whereby the public would accept the resolution of malpractice cases as being just and equitable with a minimum of claims appealed to the courts. Such a goal could be approached by a statute<sup>425</sup> compelling all claims for medical malpractice to be submitted to a joint screening panel composed of experts. Preferably, these experts would be acceptable to both parties and at least one panelist would represent the defendant's specialty or health care field. This should increase the confidence of both parties that the panel recognizes, and is able to deal with, the special interests and issues involved.

To minimize expense and maximize efficiency, the panel proceedings should be informal and settlement by compromise between the parties should be stressed. To aid in settlement, the panel should be able to recommend

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425. A recent poll by Beldon Associates in Dallas indicates that a statutory solution to the medical malpractice crisis would be readily accepted by a majority of Texans. See *The San Antonio Light*, Oct. 15, 1975, at 4-D, col. 4. For example, 80 per cent of the Texans surveyed agreed that the state legislature should immediately pass laws to deal with high malpractice insurance rates; nine per cent disagreed, and 11 per cent did not express opinions.



damages as well as resolve liability. Provisions could be incorporated into the plan allowing the parties to agree to be bound by the panel's findings and recommendations, thus eliminating the need for further appeal. The success of such a provision would greatly depend on public acceptance which could be enhanced through proper advertising and information distribution. If, however, one party appeals to the courts, the panel's findings should be admissible in evidence and the prevailing party should, within the discretion of the court, be awarded court costs and reasonable attorney's fees. To further reduce the chance of frivolous appeals, the appellant could be required to post a bond to defray the appellee's legal expenses in the event the appeal fails. In order to be sustained as constitutional, the amount of this bond must be variable and within the discretion of the court so it may be set according to the economic position of the appellant.

The primary goal is to avoid the problems and costs of litigation while creating a forum, allowing for the just disposition of claims, which does not compromise the parties' rights so well preserved by litigation. The current medical malpractice crisis is not solely a medical, legal, or insurance problem; rather, it arises out of the interrelationship of the three professions and its ultimate solution will require a concerted effort by all those involved.