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Medical Malpractice Litigation: Alternatives for Pennsylvania

Cathy J. Jones

I. INTRODUCTION

In the early and mid-1970's, the nation found itself in what has been called a medical malpractice crisis.¹ The number of medical malpractice claims was escalating, as was the dollar amount of judgments being awarded by juries to successful malpractice plaintiffs. A general dissatisfaction with the traditional methods of determining medical malpractice claims through the use of jury trials was evident, at least among health care providers and malpractice insurance carriers. Malpractice insurance premiums were skyrocketing and insurance carriers were becoming increasingly reluctant to risk coverage of physicians. The rise in insurance premiums and the carriers' reluctance to continue to provide adequate coverage led to the fears that physicians would accelerate the practice of "defensive medicine" or that some would cease to practice altogether.

In response to the "crisis," in an effort to provide medical malpractice insurance to health care providers at a reasonable cost and yet to

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provide adequate remedies for the victims of medical malpractice, many state legislatures sought alternatives to traditional malpractice litigation. The legislation proposed and adopted in many jurisdictions took various forms: some mandated nonbinding arbitration between a patient and health care provider involved in a malpractice dispute; some permitted the parties to sign a pre-treatment contract providing that any malpractice dispute arising between them would be submitted to arbitration; other legislation established panels to review medical malpractice claims either prior to the filing of such an action in a court of law or subsequent to such a filing but before the case actually reached the trial stage. The objectives of the various alternatives were similar. The drafters of the legislation hoped that such procedures would eliminate frivolous malpractice claims without the involvement of precious court resources, that many meritorious suits would be settled without the use of the courts, and that patients and health care providers would receive more just remedies, more expeditiously, than they had received pursuant to traditional malpractice litigation.

Some form of malpractice litigation alternative has been adopted in more than thirty states. The purpose of this article is to review the various alternatives enacted and to attempt to assess the effectiveness of the states' response to the malpractice "crisis." Because most of the statutory provisions vary widely, some limits must be imposed on this review. This article will focus primarily on the arbitration or review panel aspects of the alternatives—the form of the panel (that is, arbitration or medical review panel), the composition of the reviewing panel, and the process of selecting the panelists.
body, the nature of the hearing granted the parties in the proceeding, the decision rendered by the board or panel, and the availability of an appeal following the initial panel decision. The reader should be aware that many malpractice statutes, in keeping with the legislative purposes of containing the amount of judgment a malpractice claimant may receive and the amount of malpractice insurance premiums health care providers must pay, place upper limits on such judgments and make provisions for adequate malpractice coverage for health care providers. Many statutes also prescribe in detail the procedures to be followed in filing complaints, performing discovery, and otherwise conducting malpractice actions within the alternative dispute resolution systems. While recognizing the importance of all of these provisions to the effectiveness of the various malpractice statutes, it is not the purpose of this article to discuss or analyze them apart from any effect they may have on the actual operation of the system.

The article, then, has two primary foci. The first is Pennsylvania's Health Care Services Malpractice Act. The Pennsylvania Act went into effect on January 15, 1976 and provided a mandatory nonbinding arbitration system for malpractice dispute resolution. It operated in that form until September 22, 1980 when it was declared unconstitutional by the Pennsylvania Supreme Court in Mattos v. Thompson. Part II of this article sets forth a discussion of the Pennsylvania Act as it existed between 1976 and 1980, the relevant litigation which surrounded it, the ultimate holding of unconstitutionality, and the results effected by its operation. The remainder of the article is devoted to an examination of alternatives the Pennsylvania legislature may now consider in adopting a new medical malpractice litigation alternative. Each of the three alternatives—arbitration similar to that declared unconstitutional in Pennsylvania, contractual agreement to arbitrate, and medical panel review—will be discussed in the context of jurisdictions in which the specific alternatives are currently in operation. Part III of this article focuses on the arbitration system used in Maryland; Part IV discusses the contractual agreements provided in Michigan; and Part V analyzes medical review panels as they exist in Tennessee. In all instances, reference is made to other jurisdictions which differ significantly and importantly from those being discussed. Finally, results achieved pursuant to the various alternatives, in terms of claims filed and resolved, settlement amounts, etc., are set forth. Part VI of the article contains a general conclusion.

5. The author is indebted to Walter R. Tabler, Director, Health Claims Arbitration Office, State of Maryland; John A. Ianneli, Administrative Assistant to the Commissioner of Insurance, Commonwealth of Massachusetts; Nancy A. Baerwaldt, Commissioner of In-
II. THE PENNSYLVANIA HEALTH CARE SERVICES MALPRACTICE ACT

The Pennsylvania Health Care Services Malpractice Act was enacted with the purpose, *inter alia*, of establishing "a system through which a person who has sustained injury or death as a result of tort or breach of contract by a health care provider can obtain a prompt determination and adjudication of his claim and the determination of fair and reasonable compensation."\(^6\) The Act provided for the creation of a system of arbitration panels for health care,\(^7\) to be headed by an Administrator.\(^8\) The legislature mandated that the panels would have:

original exclusive jurisdiction to hear and decide any claim brought by a patient or his representative for loss or damages resulting from the furnishing of medical services which were or which should have been provided. [The Act also provided that the arbitration panel would] have original exclusive jurisdiction to hear and decide any claim asserted against a nonhealth care provider who is made a party defendant with a health care provider.\(^9\)

In other words, any patient instituting a medical malpractice action against a health care provider was required to submit the claim to arbitration rather than proceeding by way of traditional civil litigation. Upon the filing of a medical malpractice claim with the Administrator, the parties were to be given the opportunity to choose a seven member arbitration panel consisting of two attorneys, two health care providers, and three lay persons. Selection of the arbitrators was to be made from lists made available to the parties by the Administrator.\(^10\) The composition of the seven member panels and the actual selection of the arbitrators caused grave problems for the

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\(^7\) Id. § 1301.308(a).
\(^8\) Id. § 1301.301.
\(^9\) Id. § 1301.309. *But see* Mattos v. Thompson, 421 A.2d 190 (Pa. 1980), in which the Pennsylvania Supreme Court declared this section unconstitutional. *See* notes 65-77 and accompanying text *infra*.
arbitration system. As noted in the Administrator's Fourth Annual Report on the Operation of the Arbitration Panels for Health Care, in most cases the parties were unable to agree on a seven member panel. In one instance, the panel selection process alone lasted sixteen months. In reality, the parties usually agreed to forego a seven member panel, stipulating instead to arbitration before a five or three member panel, and, in many instances, panel selection was accomplished not by the parties but by the Administrator. In response to such difficulties and in response to a recommendation by the Administrator, the legislature in 1979 amended the original Act and provided that the panels would be composed of three members: one attorney, who would be designated the chairperson; one health care provider; and one lay person who was neither a health care provider nor an attorney—all of whom would be appointed by the Administrator. The amendment to the Act became effective on February 12, 1980. In a further effort to improve the speed with which malpractice claims were resolved, the 1979 amendment also provided that if the Administrator had not selected a panel within ninety days after the filing of a certificate of readiness by the parties, the Administrator was to transfer the action to a court of common pleas having venue over the case for pretrial and trial as in any other civil case.

In cases where arbitration panels were convened to hear malpractice actions, the Act commanded the panels to "expeditiously hear and determine the claim in accordance with the rules and regulations adopted by the administrator." All proceedings and hearings before the panel were to be conducted according to the common and statutory law of the Commonwealth of Pennsylvania, the Pennsylvania Rules of Civil Procedure, and the Pennsylvania rules of evidence. The panel was permitted, upon motion of any party or upon its own motion, to appoint a disinterested and qualified expert who would examine the claimant or "relevant evidentiary matter" and who would testify as a witness concerning the examination. Following the submission of all evidence and the closing of all matters in the proceeding, the panel

12. Id. at 11.
13. Id. at 10-11.
16. Id. § 1301.402.
17. Id. § 1301.506.
18. Id. § 1301.507.
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was authorized to make a determination as to liability and to award damages to the injured party.\(^{19}\)

Appeals from panel determinations were by way of trial de novo to the Pennsylvania court of common pleas.\(^{20}\) Where an appeal was taken to a court of common pleas, the arbitration panel's findings of fact, but not its award of damages, were admissible into evidence before the judge or jury trying the matter.\(^{21}\) If no appeal was taken from the panel's decision, the party prevailing before the panel could request that the record of the proceedings and the panel's judgment be transferred to the court of common pleas for execution in the district where any of the parties resided.\(^{22}\)

Most of the litigation surrounding the Pennsylvania Health Care Services Malpractice Act involved section 309 setting forth the jurisdiction of the panels and section 502 permitting the joinder of additional parties "who may be necessary and proper to a just determination of the claim" and granting the arbitration panel "jurisdiction over such additional parties whether they be health care providers or nonhealth care providers."\(^{23}\)

Section 309 questions have arisen primarily in two contexts: where medical malpractice actions were instituted in federal district courts in Pennsylvania and where actions were instituted in state courts against nonhealth care providers who joined health care providers as additional defendants. The leading federal case involving section 309 of the Pennsylvania Health Care Services Malpractice Act was *Edelson v. Soricelli*.\(^{24}\) There, a plaintiff suing a health care provider for malpractice argued that the Act was procedural and not substantive and that the requirement that the claim be submitted to an arbitration panel before instituting suit pursuant to the federal court's diversity jurisdiction was thus obviated. The plaintiff also argued that the performance of the arbitration system had been so dismal that to impose the arbitration requirement precluded the full and fair adjudication of such claims in the federal court. The court held, however, that medical malpractice plaintiffs were required to submit their claims to malpractice arbitration panels for resolution before invoking the jurisdiction of the federal court.\(^{25}\) In *Hamilton v. Roth*\(^{26}\) a state prisoner instituted a medical malpractice suit in federal district court arguing that because his was a pendent jurisdiction and not a diversity jurisdiction case,

\(^{19}\) Id. § 1301.508(a)(9).
\(^{20}\) Id. § 1301.509.
\(^{21}\) Id. § 1301.510.
\(^{22}\) Id. § 1301.511(a).
\(^{23}\) Id. § 1301.502.
\(^{24}\) 610 F.2d 131 (3d Cir. 1979).
\(^{25}\) Id. at 141.
\(^{26}\) 624 F.2d 1204 (3d Cir. 1980).
Edelson v. Soricelli was inapplicable and that he was not required to first seek relief before an arbitration panel. The court disagreed, stating that the different jurisdictional basis was irrelevant and that the plaintiff was indeed required to first pursue his malpractice claim before an arbitration panel.27

A different outcome was reached by the Pennsylvania Superior Court when it considered the issue of whether the arbitration panel had jurisdiction over a trespass action filed by a plaintiff against a nonhealth care provider defendant who then joined a health care provider as an additional defendant. In Staub v. Southwest Butler County School District28 a student injured in a school physical education class instituted suit against the school district. The school district, in turn, joined as defendants the physicians and hospital responsible for the student’s medical treatment alleging that they were responsible for any injury to the student. In holding that original jurisdiction remained with the court of common pleas in which the suit was instituted, the superior court noted that in terms of nonhealth care providers section 309 vests original, exclusive jurisdiction with arbitration panels for health care when a claim is instituted by a patient or patient representative and the claim is against a nonhealth care provider who is made a party to the action with a health care provider.29 In Staub, the court noted, the plaintiff made no claim against a health care provider. The plaintiff chose to litigate her action, the court continued, in the court of common pleas, and she could not be denied that choice of forum by a defendant merely by the defendant’s joining a health care provider as an additional defendant.30 The court recognized that the defendant tortfeasor was entitled to seek contribution from a health care provider to the extent that medical negligence caused the plaintiff’s injuries. That right could be adequately protected by joining the health care provider in the original action before the court of common pleas. The court acknowledged that such a procedure could result in the finding of malpractice liability without proceeding before an arbitration panel, but that in the absence of legislation prohibiting such a procedure, the economics of time and personnel dictated that all of the issues in the case be resolved in the one action before the court of common pleas.31 In the later case of Taglieri v. Logansport Machine Co.32 the superior court, moreover, concluded that the court of common

27. Id. at 1210-12.
29. Id. at 419, 398 A.2d at 206.
30. Id. at 419-20, 398 A.2d at 207.
31. Id. at 420-21, 398 A.2d at 207.
pleas will not be deprived of jurisdiction in such an action even where the plaintiff has simultaneously filed and has pending a medical malpractice action before an arbitration panel. A similar decision was reached by the federal district court in Zielinski v. Zappala, where Taglieri was relied upon in a diversity action in deciding that section 309 does not require a trial court to defer to arbitration where the allegation of medical malpractice is contained in a third-party claim filed by a non-patient seeking contribution from a physician.

Litigation arose concerning section 502 of the Act because of the attempt by health care providers to apply its language—"The arbitration panel shall have jurisdiction over such additional parties whether they be health care providers or nonhealth care providers"—literally. In a series of cases, health care providers sued for malpractice attempted to join as additional defendants the brother of the victim who struck the victim with a snowball causing the original injury, a fraternal organization operating a lodge where the plaintiff was assaulted before the alleged negligent medical treatment, and the architect of and manufacturer of window glass of a hospital psychiatric ward from which a patient leaped to his death. In all three cases, the Administrator had refused to allow the health care provider defendants to join the nonhealth care providers and these decisions were affirmed by the appellate court. In affirming the Administrator's decisions, the court reasoned that the legislature never intended that the arbitration panels would decide any questions other than those involving medical malpractice and that although section 502 permits the joinder of any additional party necessary and proper to a determination of the claim before the panel, the claim intended to be determined was for loss or damages resulting from medical services. In the precedential decision of Gillette v. Redinger the court first addressed the term "nonhealth care provider" and determined that the term did not encompass all persons excluded from the definition of "health care provider," "but rather was intended to encompass those persons who, like manufacturers of drugs or medical instruments ... are kindred to health care providers." Accordingly, the joinder of the party who may have been

33. Id. at 460, 405 A.2d at 525.
responsible for the initial injury was not necessary to a determination of whether the health care provider defendant was guilty of malpractice. The court noted that the only issue before the panel was the alleged failure of the health care provider to treat the plaintiff's injury and that if the question of how the injury occurred was germane to the malpractice question, the alleged original tortfeasor could be called to testify without that person's liability being relevant to a panel decision. To hold otherwise, the court said, would be to vest the panels with jurisdiction over virtually every type of tort claim contributing, however remotely, to the plaintiff's injury. The jurisdiction of the panels over nonhealth care providers was limited, therefore, to those nonhealth care providers intimately related to the process of furnishing medical services such as manufacturers of drugs or equipment used by health care providers in administering medical care.

The case of *Firich v. American Cystoscope Makers, Inc.* presents an interesting twist of the issues presented above concerning sections 309 and 502 of the Act. In *Firich* the plaintiff sued four nonhealth care providers/equipment manufacturers on the basis of products liability. The nonhealth care providers then joined as additional defendants health care providers allegedly responsible for the plaintiff's injuries. The federal district court distinguished the decisions reached in *Zielinski v. Zappala*, *Taglieri v. Logansport Machine Co.*, and *Staub v. Southwest Butler County School District* on the basis that in those cases the original cause of action arose from a set of facts not involving the delivery of medical services. In *Firich*, however, the plaintiff alleged that he was injured by a defective piece of medical equipment manufactured by the four corporations and that the injury occurred during the administration of medical services. The original suit, then, focused on an integral component of a medical procedure. The *Firich* court held, therefore, that a patient filing suit against a nonhealth care provider, as defined in *Gillette* as being subject to arbitration panel jurisdiction, must file the claim with the panel when the patient can

40. *Id.* at 475, 383 A.2d at 1298.
41. *Id.* at 475-76, 383 A.2d at 1298.
42. *Id.* at 474, 476; 383 A.2d at 1298. *See also* Morrison v. Therm-O-Rite Products Corp., 468 F. Supp. 1295 (M.D. Pa.), *aff'd mem.*, 612 F.2d 574 (3d Cir. 1979).
44. 470 F. Supp. 351 (E.D. Pa. 1979); *see text accompanying note 34 supra.*
45. 266 Pa. Super. Ct. 456, 405 A.2d 524 (1979); *see text accompanying notes 32-34 supra.*
47. 482 F. Supp. at 1051.
48. 34 Pa. Commw. Ct. at 475, 383 A.2d at 1298; *see text accompanying notes 35, 38-42 supra.*
reasonably expect the nonhealth care provider to join a health care provider as an additional defendant.\textsuperscript{49}

The original constitutional challenge to the Pennsylvania Health Care Services Malpractice Act was decided by the Supreme Court of Pennsylvania in 1978 in the case of \textit{Parker v. Children's Hospital}.\textsuperscript{50} The court held in \textit{Parker} that the Act was constitutional. Although that holding has since been overruled by the same court in \textit{Mattos v. Thompson},\textsuperscript{51} the \textit{Parker} decision is worthy of discussion here because the Pennsylvania Supreme Court itself devoted a large part of its \textit{Mattos} decision to discussing \textit{Parker} and because the rationale set forth in \textit{Parker} for the constitutionality of the Act is representative of that set forth by the courts of many jurisdictions in support of the constitutionality of alternative malpractice dispute resolution systems.\textsuperscript{52}

\textsuperscript{49} 482 F. Supp. at 1053.
\textsuperscript{50} 483 Pa. 106, 394 A.2d 932 (1978).
\textsuperscript{51} 421 A.2d 190 (Pa. 1980); see text accompanying notes 65-73 infra.
\textsuperscript{52} See, e.g., \textit{DiAntonio v. Northampton-Accomack Memorial Hosp.}, 628 F.2d 287 (4th Cir. 1980) (provision of Virginia Medical Malpractice Act permitting admission into evidence at trial of medical review panel's opinion did not interfere with function of jury; also, Act's requirement that malpractice plaintiffs but not other tort plaintiffs submit their complaints to panels as a prerequisite to court action did not constitute a violation of equal protection rights because the elimination of frivolous claims and the provision and promotion of mediation and settlement of such claims provides a rational basis aimed at achieving a legitimate state interest); \textit{Woods v. Holy Cross Hosp.}, 591 F.2d 1164 (6th Cir. 1979) (Florida Medical Malpractice Law establishing medical review panels does not burden a plaintiff's right to trial by jury nor does the admissibility of the panel's opinion at trial invade the province of the jury; also, the law did not violate due process or equal protection principles). The \textit{Woods} court did indicate that there could be constitutional problems involved with a nonconsensual system of arbitration. The constitutionality of the Florida statute had previously been upheld by the Supreme Court of Florida in \textit{Carter v. Sparkman}, 335 So. 2d 603 (Fla. 1976), \textit{cert. denied}, 429 U.S. 1041 (1977). The statute was recently held to be unconstitutional, \textit{Aldana v. Holub}, 381 So. 2d 231 (Fla. 1980), on the basis that the nonextendable 10 month time period in which panel review had to be completed or the case transferred to a trial court was arbitrary, capricious, and a denial of due process. The \textit{Aldana} court stated, however, that its decision reflected that the system itself was not working well, not that the wisdom expressed by the court in \textit{Carter} v. \textit{Sparkman had not been correct}. \textit{Id.} at 237.

\textit{See also \textit{Hines v. Elkhart General Hosp.}}, 465 F. Supp. 421 (N.D. Ind.), \textit{aff'd}, 603 F.2d 646 (7th Cir. 1979) (Indiana Medical Malpractice Act establishing medical review panels did not infringe on claimants' right to trial by jury, did not deny them access to the courts, and did not violate equal protection principles); \textit{Eastin v. Broomfield}, 116 Ariz. 576, 570 P.2d 744 (1977) (submission of medical review panel findings to jury does not violate right to trial by jury and requirement that medical malpractice claimants proceed through panel system as condition precedent to court action does not violate equal protection principles; bond requirement of statute held unconstitutional); \textit{Prendergast v. Nelson}, 199 Neb. 97, 256 N.W.2d 657 (1977) (Nebraska's Hospital Medical Liability Act providing for medical review panels does not violate due process or equal protection principles, does not deny malpractice plaintiffs' access to the courts, and does not permit the invasion of the function of the jury merely because the panel's opinion is admissible into evidence before the jury); \textit{Comiskey v. Arlen}, 55 App. Div. 2d 304, 390 N.Y.S.2d 122 (1976), \textit{aff'd}, 43 N.Y.2d
The supreme court began its analysis in *Parker* with the presumption that the Act was constitutional and placed the burden on the plaintiffs challenging the Act to prove that it was clearly, palpably, and plainly unconstitutional. The plaintiffs' first argument in support of their contention that the Act was unconstitutional was that it violated article I, section 6 of the Constitution of Pennsylvania guaranteeing them a right to trial by jury. The court conceded that the right to jury trial was a right to be protected, but that it was not to be protected to the exclusion of all other methods of dispute resolution. The court had previously held that the imposition of arbitration as a condition precedent to litigation did not constitute a *per se* violation of article I, section 6. Such a prerequisite was valid, the court continued, so long as the right to trial by jury was available to the parties prior to a final determination of their respective rights and so long as the right of presenting the issue to be determined to the jury was not burdened by onerous conditions, restrictions, or regulations which made the right practically unavailable.

696, 372 N.E.2d 34, 401 N.Y.S.2d 200 (1977) (admissibility of medical review panel's opinion into evidence does not invade province of jury and New York medical malpractice law neither violates equal protection or due process principles nor does it deny malpractice claimants access to the courts); State *ex rel.* Strykowski v. Wilkie, 81 Wis. 2d 491, 261 N.W.2d 434 (1978) (Wisconsin medical malpractice act does not constitute an improper delegation of the judicial function to an administrative body, does not deny access to the courts to malpractice claimants and does not violate equal protection and due process rights; submission of medical review panel opinions to the jury does not violate claimants' right to trial by jury and presence of health care provider on panel does not lead to assumption of bias on part of panel).

But cf. Wright v. Central Du Page Hosp. Ass'n., 63 Ill. 2d 313, 347 N.E.2d 736 (1976) (Illinois statute permitting decision of medical review panel composed of physicians and attorneys to become final determination in certain cases without subsequent court action constitutes improper delegation of judicial function and impermissible restriction on right to trial by jury and is unconstitutional); State *ex rel.* Cardinal Glennon Memorial Hosp. for Children v. Gaertner, 583 S.W.2d 107 (Mo. 1979) (Missouri statute requiring submission of medical malpractice claims to review board as prerequisite to filing action in court constitutes violation of Missouri constitutional provision that courts be open to every person and afford a remedy for every injury, and that justice be administered without sale, denial, or delay; the court indicated that a system by which claims would be referred to review panels after being filed with a court could possibly withstand a constitutional challenge); Simon v. St. Elizabeth Medical Center, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (1976) (Ohio statute requiring arbitration of malpractice actions constitutes unconstitutional infringement on the judicial function, a violation of the right to trial by jury, and a violation of equal protection and due process rights).

53. 483 Pa. at 116, 394 A.2d at 937.

54. “Trial by jury shall be as heretofore, and the right thereof remain inviolate. The General Assembly may provide, however, by law, that a verdict may be rendered by not less than five-sixths of the jury in any civil case.” PA. CONST. art. I, § 6 (amended 1971).


56. 483 Pa. at 119, 394 A.2d at 939 (quoting Smith Case, 381 Pa. at 231, 112 A.2d at 629).
The plaintiffs argued, however, that the difficulty and expense involved in trying malpractice cases and the actual result of the arbitration requirement (that the case, in effect, be tried twice) created an onerous condition which did make the right to jury trial practically unavailable. The court adamantly rejected the assumption that the arbitration requirement imposed a two-tiered trial scheme. The purpose of the Act, the court said, was to provide an expeditious disposition of malpractice actions and to avoid the delays inherent in the litigation process. Contrary to the plaintiffs' assertion that the Act imposed a burden on them, the court found that the arbitration system would provide a swifter adjudication of their claims at a minimal cost. At the same time, it would guarantee the satisfaction of any judgment obtained and, through the imposition of costs on any party found by the court to have prosecuted a capricious or unreasonable appeal, would discourage frivolous and dilatory appeals. The question, the court said, was not the curtailment of the right to trial by jury, but merely its postponement. And, where the reason for that postponement constitutes a compelling state interest and the procedure followed is reasonably designed to effectuate the desired objective, the resulting delay is not an unconstitutional encroachment upon the right. The court found that the state's interest in attempting to streamline and make more efficient the medical malpractice system in light of the malpractice crisis was a compelling one and that the procedures it employed were reasonably designed to effectuate that interest. Accordingly, the court held that the medical malpractice arbitration system did not unconstitutionally infringe upon the plaintiffs' right to trial by jury in medical malpractice actions. 57

The plaintiffs also argued that statistics proved that the arbitration system was not achieving its intended goal in that medical malpractice cases were not being resolved more quickly and efficiently than they would have been pursuant to a traditional litigation system. 58 The court rejected this argument as well, stating that the time period covered by the statistics was too short to conclude that the legislative scheme was incapable of achieving its stated purpose or that the system's administrator was unable or unwilling to administer the system in a way that would insure a prompt and fair resolution. Deference to a coequal branch of government, the court stated, required that it allow a reasonable period of time to test the effectiveness of the legislation. 59

57. 483 Pa. at 119-21, 394 A.2d at 939-40.
58. In his dissenting opinion, Justice Larsen stated that as of August 31, 1978, 1,270 cases had been filed with the arbitration panels for health care and only 2 had been resolved. 483 Pa. at 132, 394 A.2d at 945 (Larsen, J., dissenting).
59. 483 Pa. at 121, 394 A.2d at 940.
The trial court in *Parker* had held unconstitutional section 510 of the Act which permitted the parties at a de novo trial to introduce into evidence the opinion of the arbitration panel. The supreme court reversed the trial court on that point. Section 510, the court said, did not transform the opinion into a presumption, nor did it shift the burden of going forward with evidence or the ultimate burden of proof. Despite section 510, the judge or jury remained the final arbiter of the facts and the issues raised and presented. The court rejected the plaintiffs' argument that the admission of the panel's opinion would have a coercive effect on the jury and, accordingly, held the section to be constitutional.60

The plaintiffs also argued that the Act violated article V of the Constitution of Pennsylvania61 by vesting judicial power in an arbitration panel and by delegating a judicial function to the Administrator. The court said that the legislature in enacting the Health Care Services Malpractice Act did not remove a traditional judicial function from the judiciary. Rather, it merely added a new administrative remedy. The exercise of adjudicative functions by administrative bodies does not result in the withdrawal of judicial functions contrary to the doctrine of separation of powers. The legislature neither infringed upon nor set aside any judicial powers in creating the office of Administrator or the panels and the full judicial rights of the parties remained intact through their right to take an appeal to a trial de novo from the panel's decision.62

The plaintiffs next argued that the inclusion of health care providers on the arbitration panels constituted an impermissible bias and conflict of interest. The court disagreed and noted, *inter alia*, that the health care providers constituted only a minority of the panel members, that the plaintiffs asserted no facts to support their allegation of bias, and that the rules and laws applied by the panel members were derived from the judge-made common law of Pennsylvania and not from any persons pecuniarily interested in the outcome of the cases before the panels. Furthermore, the court refused to presume that health care providers sitting on the arbitration panels would ignore the facts and the law applicable to the cases before them.63

Finally, the court rejected the plaintiffs' argument that the Administrator's appointing of the panel and the panel chairperson's tak-

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60. *Id.* at 121-25, 394 A.2d at 940-42.

61. Article V vests the judicial power of the Commonwealth "in a unified judicial system consisting of the Supreme Court, the Superior Court, the Commonwealth Court, courts of common pleas ... and such other courts as may be provided by law . . . ." Pa. Const. art. V, § 1.

62. 483 Pa. at 125-27, 394 A.2d at 942-43.

63. *Id.* at 128-30, 394 A.2d at 943-44.
ing part in panel deliberations after instructing the panel in the law applicable to the case were unconstitutional acts.\textsuperscript{64}

By the time the Act was again challenged on constitutional grounds in \textit{Mattos v. Thompson},\textsuperscript{65} the patience of the Pennsylvania Supreme Court had expired. The court was unwilling to defer any longer to the coequal branch of government in according further time to test the effectiveness of the legislation. After once again rejecting the argument that the arbitration panel system denies medical malpractice victims procedural due process because of the presence of a physician on the panel,\textsuperscript{66} and after reviewing its previous decision in \textit{Parker v. Children's Hospital},\textsuperscript{67} the court went on to discuss the actual results of the medical malpractice arbitration system, results that culminated in the finding of unconstitutionality.

The facts, as found by the commonwealth court and as adopted by the supreme court, were startling: Between April 6, 1976 and December 31, 1979, 2,909 medical malpractice claims had been filed with the Administrator; of these, a certificate of readiness had been filed in only 134 cases. Of the 134 cases, 14 had been tried before arbitration panels, 23 had been settled during panel selection, 1 had been continued, and 96 were still awaiting disposition. Of the 96 unresolved cases, arbitration hearings had been scheduled in 7, prehearings had been scheduled or held in 12, panel selection was underway in 54, and panel selection had been completed in 23. Of the total 2,909 cases, 698 had been disposed of by means of dismissal, transfer to courts of common pleas, discontinuance, settlement, or \textit{non pros}.\textsuperscript{68} The court went on to add that the system had not improved since the commonwealth court had made its findings of fact: As of May 31, 1980, a total of 3,452 cases had been filed with the Administrator and only 936 had been resolved, settled, or terminated. Seventy-three percent of all cases filed pursuant to the arbitration system remained unresolved at that time.

\textsuperscript{64} \textit{Id.} at 130-31, 394 A.2d at 944-45.
\textsuperscript{65} 421 A.2d 190 (Pa. 1980).
\textsuperscript{66} \textit{Id.} at 191-92.
\textsuperscript{67} \textit{Id.} at 192-94.
\textsuperscript{68} \textit{Id.} at 194. Although not directly relevant to the efficiency and effectiveness of the malpractice arbitration system, it is interesting to note that of the 14 cases tried by the panels, 13 resulted in verdicts, 8 for the plaintiff and 5 for the defendant, and 1 was settled. Of the 13 verdicts, by December 31, 1979, 6 had been appealed to the courts of common pleas and the appeal period for a seventh was still pending. One of the cases appealed had been decided by a court of common pleas and the verdict reached was the same as rendered by the arbitration panel. Of the 698 cases which had been resolved, 395 had been settled with disclosure of the amount of settlement, 15 had been dismissed, 76 were discontinued by issue of \textit{non pros}, and 57 had been transferred to courts of common pleas. \textit{Id.}
and 6 of the original 48 cases filed during the system's first year of operation (1976) had not yet been resolved.  

Finding that sufficient time had passed from the inception of the arbitration system to allow for a meaningful evaluation of its performance, the court concluded:

Such delays are unconscionable and irreparably rip the fabric of public confidence in the efficiency and effectiveness of our judicial system. Most importantly, these statistics amply demonstrate that "the legislative scheme is incapable of achieving its stated purpose." [Citing Parker.]

We are compelled, therefore, to declare unconstitutional section 309 of the Act, 40 P.S. § 1301.309, giving the health care arbitration panels "original exclusive jurisdiction" over medical malpractice claims because the delays involved in processing these claims under the prescribed procedures set up under the Act result in an oppressive delay and impermissibly infringes [sic] upon the constitutional right to a jury.  

The court went on to add that its holding should not be interpreted as a retreat from its "long-held belief" in arbitration as a viable method of dispute resolution. Instead, the holding "merely indicates the inability of this statutory scheme to provide an effective alternative dispute resolution forum in the area of medical malpractice."  

Because the court held unconstitutional only section 309 of the Act conferring original exclusive jurisdiction of medical malpractice cases on the arbitration panels, questions arose as to the viability of the remainder of the Act. In an opinion issued to the Administrator for Arbitration Panels for Health Care, the Attorney General of Pennsylvania stated that the Act, with the exception of section 309, remained intact and that the arbitration system was merely transformed from an involuntary one to one which is voluntary and nonbinding in nature. The Attorney General also concluded that because the supreme court invalidated section 309 on the basis that it imposed an impermissible infringement on the right to trial by jury and because defendants as well as plaintiffs are entitled to trial by jury, plaintiffs could not have the option of proceeding with voluntary arbitration under the Act without the consent of all defendants and all additional

69. Id. at 195.
70. Id. at 195-96.
71. Id. at 196.
73. 10 Pa. Bull. at 4280.
defendants; to do otherwise, the Attorney General reasoned, would be
to compel defendants to accept an "oppressive delay" in derogation of
their right to trial by jury. The Attorney General instructed the Ad-
ministrator, then, that he and the arbitration panels could continue to
accept and docket new complaints, decide motions, hold hearings, and
render decisions on new or presently pending cases only with the con-
sent of all parties to the action. If any party refused such consent, the
case must be transferred to the appropriate court of common pleas.
The Administrator was also instructed to notify by mail all parties in-
volved in actions before the Administrator and panels of the Attorney
General's interpretation of the system as a voluntary, nonbinding one
and of the option to submit to arbitration under the Act. The parties
were also to be advised that if they failed to respond withholding their
consent, such consent to voluntary arbitration would be presumed.
By January 31, 1981, of the 2,514 cases pending before the arbitration
panels, 2,157 had been transferred to Pennsylvania courts of common
pleas and 357 remained with the panels.

Despite the obvious failings of the medical malpractice arbitration
system in Pennsylvania and the supreme court's decision holding the
Act to be unconstitutional in part, a word must be said by way of ex-
planation of, if not excuse for, the operation of the system. Of those
2,909 cases which had been filed with the arbitration panels by
December 31, 1979, 1,273, or 43.8 percent had been filed within 1979
itself. By September 30, 1980, a total of 3,925 cases had been filed with
the panels with 1,016, or 25.9 percent of the total having been filed in
1980. By September 30, 1980, the number of cases having been disposed
of by panel decision had risen from 14 to 56 and, by that date, 120
more cases were pending for panel decision. Following the filing of a
certificate of readiness, 35 percent of all cases were settled by the par-
ties prior to a panel hearing. Fifty percent of the cases were appealed
to courts of common pleas following a panel decision.

According to the Executive Deputy Administrator for Arbitration
Panels for Health Care, much of the delay in the system "is caused

74. Id.
75. Id.
76. Id.
These figures support the prediction made by the Executive Deputy Administrator of the
Arbitration Panels for Health Care that following transition of the arbitration system to a
voluntary basis, "We do not believe that many litigants will avail themselves of our ser-
vices under these circumstances." Letter from R. Peter Ericson to the author (November
7, 1980).
78. Mr. Ericson's answers to a questionnaire submitted to him by the author [hereinafter cited as Pennsylvania Questionnaire Response].
79. Id.
Alternatives to Medical Malpractice Litigation primarily by counsel." Since panel selection does not begin until counsel files a certificate of readiness in a case, it is important to note that in the 3,925 cases filed with the system by September 30, 1980, counsel had filed only 277 certificates of readiness. Steps have been taken to alleviate the delay. As noted earlier, panel membership has been cut from seven to three and the method of selecting panel members has been streamlined. A new rule has also been promulgated that became effective on February 12, 1980, requiring certificates of readiness to be filed within one year of the date on which a claim is initially filed. In the opinion of the Executive Deputy Administrator, "The system does work well and expeditiously for those who actively pursue their claims." It should also be noted that the Administrator's office handles up to 200 claims each month, faster than the courts of common pleas. Finally, the system is entirely self-supporting, being financed by fees levied against health care providers, and has ended each operating year with a surplus.

Whether the Pennsylvania Arbitration Panels for Health Care would have begun to operate more effectively and expeditiously under the Act's new provisions and accompanying regulations is no longer a rele-

80. Id.
81. Id.
82. See text accompanying notes 10-14 supra.
83. The newly promulgated regulation provides:

In all actions commenced prior to the effective date of this section, the parties shall file a certificate of readiness within one year after the effective date of this section.

In all actions commenced on or after the effective date of this section, the parties shall file a certificate of readiness within one year after the commencement of the action.

37 PA. CODE 171.123(a) (1980); see Justice Roberts' dissent in Mattos v. Thompson, 421 A.2d at 198 (Roberts, J., dissenting), where he deemed this adjustment to the Malpractice Act the most significant. The other modifications mentioned by Justice Roberts were the reduction in size of the panels from seven to three, PA. STAT. ANN. tit. 40, § 308(b) (Purdon Supp. 1980-1981); the elimination of the "strike list" method of selecting panel members and the substitution of Administrator-appointments instead, id. § 308(a); and the reduction of parties' peremptory challenges from six to one, id. § 308(c). 421 A.2d at 198 (Roberts, J., dissenting).

Pursuant to Mattos v. Thompson and the Attorney General's official opinion No. 80-2, reprinted in 10 Pa. Bull. 4279 (Nov. 1, 1980), see note 72 supra, several new rules and regulations have been promulgated amending 37 PA. CODE §§ 171.6, .7, .8, .155. They became effective upon publication in 11 Pa. Bull. 407 (Jan. 24, 1981). These additions provide a procedure for parties to consent to the jurisdiction of the Arbitration Panels for Health Care and procedures for the parties to stipulate to waive their rights to request a trial de novo following the decision of an arbitration panel so that finality in the arbitration system will be promoted. Id.

84. Pennsylvania Questionnaire Response, supra note 78.
85. Id.
86. Id. See also Fourth Annual Report, supra note 11, at 2-3.
vant point, however. The Pennsylvania Supreme Court has changed the system from one of involuntary to one of voluntary nonbinding arbitration. There are grave doubts concerning whether many litigants will avail themselves of the system. What is more likely is that the Pennsylvania legislature will now search for another alternative to traditional malpractice litigation. The remainder of this article will focus on the alternatives currently available to Pennsylvania and on the likelihood that any of these alternatives will serve the legislative objective of providing swift, fair justice to medical malpractice claimants and health care providers involved in malpractice litigation.

III. MANDATORY NONBINDING ARBITRATION

Perhaps the most obvious medical malpractice litigation alternative available to the Pennsylvania legislature is a system of mandatory arbitration which would withstand a constitutional challenge. Such an alternative is operative in Maryland and has withstood a constitutional attack. In Maryland, all medical malpractice claims arising in the State of Maryland must be pursued through arbitration prior to the institution of court action on the matter. The arbitration requirement has also been held to be applicable to malpractice cases brought under the diversity jurisdiction of the federal courts sitting in Maryland.

Once a medical malpractice claim is filed with the Director of the Health Claims Arbitration Office, a three member panel is chosen by the parties and the Director from lists of qualified persons maintained by the Director. The panel consists of one attorney, who serves as the panel chairperson, one health care provider, preferably from the specialty of the health care provider/defendant; and one member of the

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92. Id. § 3-2A-05(c).
general public who is not an attorney, health care provider, or agent or employee of an insurance company. The parties may agree to submit their case to a single arbitrator. In any event, in the absence of a showing of malice or bad faith, each arbitrator is immune from suit for any act or decision made during his or her tenure as an arbitrator and within the scope of his or her designated authority.

The arbitrators are charged with the responsibility of deciding all issues of fact and law raised by the complaint and response. The panel first determines whether or not the health care provider is liable to the claimant. If a finding of liability is made, the panel then considers, assesses, and apportions appropriate damages against one or more of the health care providers found to be liable. The panel's authority to assess damages is not limited to compensatory damages, but includes punitive damages as well. Therefore, merely because a claimant seeks punitive damages, he or she is not excused from the arbitration requirement and must proceed through arbitration before presenting the matter to a court for resolution.

Following a decision by the panel, if no party rejects the decision within ninety days of its being served on the parties or within thirty days of its being modified by the panel, it becomes final and binding on the parties. If any party does reject the panel's decision, he or she must file a notice of rejection with the Director and the other parties and their counsel and must file an action in court to nullify the award. Any party may elect to have the subsequent action tried to a jury. Any allegation that the award is in error because of a miscalculation of damages or because the award is in an imperfect form or that the award is invalid due to corruption, fraud, impartiality on the part of the arbitrators, or an abuse of authority by the arbitrators, is determined by the court sitting without a jury. Such allegations must be raised by a pretrial preliminary motion or they are waived. If the court finds that the award is incorrect because of a miscalculation or incorrect form, it shall modify or correct the award.

93. Id. § 3-2A-03(c).
94. Id. § 3-2A-04(e).
95. Id. § 3-2A-04(f) (Supp. 1980).
96. Id. § 3-2A-05(a) (1980).
97. Id. § 3-2A-05(d).
98. Id.
101. Id. §§ 3-2A-06(a), (b).
102. Id. § 3-2A-06(b).
103. Id. § 3-2A-06(c).
104. Id.
The rejecting party may still proceed to trial substituting the amended award for the original one. If the court finds that an allegation of corruption, fraud, partiality, or abuse is true, the court shall vacate the original award and the trial shall proceed as if there had been no original award. Unless the award is vacated by the court, the arbitration award is admissible into evidence in the subsequent judicial proceeding and is presumed correct. The burden of proving its incorrectness is placed on the party rejecting it. If the verdict in the subsequent proceeding is not more favorable to the party rejecting the panel's original award than was the original award, the costs of the judicial proceedings shall be assessed against the rejecting party.

Despite a multi-pronged attack, the Maryland Health Care Malpractice Claims Act was held to be constitutional in Attorney General v. Johnson. The Act was first attacked on the basis that it constituted an improper delegation of judicial authority to an administrative agency. The court rejected that argument stating that a condition precedent to court action in the form of arbitration does not impermissibly transgress separation of powers principles. The essence of judicial power, the Johnson court said, is the final authority to render and enforce judgment. Since the panel has no such authority, its establishment by the Act does not constitute an improper delegation of judicial power. Furthermore, the court stated, the panels are independent, they are chosen and compensated by the parties themselves, and they are dissolved following the conclusion of only a single case.

The plaintiffs next argued that the financial burden and delay placed upon them by the arbitration requirement effectively barred their access to the courts. The bar association joined the attack and argued that a number of "infringements"—the admissibility into evidence of the panel decision with the presumption of correctness; the failure to allow an attack before the jury on the possible corruption, fraud, or partiality of the arbitrators; the failure to allow voir dire of the panel members; and the cost and delay of arbitration—taken together, result in denial of access to the courts to malpractice claimants. The court refused to find that any or all of these grounds constitute a deprivation of the right to trial by jury or a bar to access to the courts.

The admissibility of the panel's decision into evidence at a subsequent trial, the court said, is a simple rule of evidence and does not

105. Id.
106. Id.
107. Id. § 3-2A-06(d).
108. Id. § 3-2A-06(e).
110. Id. at 283-87, 385 A.2d at 63-65.
111. Id. at 291, 385 A.2d at 67.
violate the right to trial by jury. The presumption of correctness is merely a proper legislative enactment concerning the burden of proof. The fact that the jury is not given the opportunity to consider whether panel members may have been biased, corrupt, or partial has no relevance to the question of whether the parties received that to which they were entitled—an appeal to a jury de novo. The inability of the parties to conduct a voir dire of the arbitrators, the court found, does not constitute a denial of due process. The parties receive biographical information about each person whose name appears on the list of eligible arbitrators and the parties are given the opportunity to strike the names of objectionable persons from the lists. Furthermore, awards may be vacated by the courts on the basis that arbitrators were not impartial, and any party may reject any award and proceed to trial following the entry of the panel's decision.

The court also refused to void the arbitration system on the basis of the alleged expense and delay it caused litigants. The law, the court noted, may impose reasonable restrictions on the right of access to the courts. It is permissible for the legislature to exercise its police power for the benefit of the public health by attempting to decrease the cost of medical malpractice insurance premiums payable by health care providers and, accordingly, the cost of medical expenses paid by patients. The expense and delay occasioned by the malpractice arbitration system in Maryland, the court found, was not so unreasonable in relation to its legitimate goal that it contravened the parties' due process rights. Unlike the Supreme Court of Pennsylvania in Mattos v. Thompson, the Supreme Court of Maryland found no pretrial conditions or procedures within the arbitration system which were so burdensome or oppressive that the claimants' right of access to the courts and right to trial by jury were made "practically unavailable."

Finally, the plaintiffs argued that the statutory classification requiring arbitration of medical malpractice claims violated their equal protection rights. In analyzing the equal protection challenge, the court held that the Act did not infringe upon or interfere with the exercise of any fundamental right and that, therefore, the rational basis, rather than the strict scrutiny, standard for deciding equal protection claims was applicable. In applying the rational basis test, the court held that the legislature's distinction between malpractice claimants and other

112. Id. at 292, 294, 385 A.2d at 68, 69.
113. Id. at 296, 385 A.2d at 70.
114. Id. at 297, 385 A.2d at 70.
115. Id. at 298-300, 385 A.2d at 71-72.
116. 421 A.2d 190 (Pa. 1980); see notes 65-73 and accompanying text supra.
117. 282 Md. at 306, 385 A.2d at 75-76.
118. Id. at 309-10, 385 A.2d at 77-78.
tort claimants was reasonably related to the legitimate purpose of the Act, that is, the protection of the public health and welfare by assuring the availability of malpractice insurance to health care providers at reasonable rates.\textsuperscript{119} The court stated that it would reach the same result even under a means-focused or substantial relationship test because the Act bears a fair and substantial relationship to the goal of encouraging the resolution of medical malpractice claims without the use of judicial proceedings, thereby holding down the costs of medical malpractice insurance and the cost of medical care in general.\textsuperscript{120}

Although the Maryland Health Care Malpractice Claims Act became legally effective on July 1, 1976, because of the constitutional attacks upon it, it did not go into practical operation until July or August, 1978.\textsuperscript{121} By March 10, 1981, approximately 750 cases had been filed with the Maryland Health Claims Arbitration Office. Of that number, arbitration had been completed in 44 and arbitration was pending in approximately 575. According to the Director of the Maryland Health Claims Arbitration Office, 75 to 80 percent of the cases filed are settled by the parties prior to the rendering of a decision by the arbitration panel.\textsuperscript{122}

The Director attributes the delay in deciding the remaining 575 cases to several causes. At the inception of the arbitration program, he stated, there were too few attorney and health care provider arbitration panelists available. That problem no longer exists, however, since the program has become better known and since the per diem rates for arbitrators have been more than doubled. The Director also noted that the system's original director was absent because of illness throughout most of his term. Some cause for delay is attributable to the parties, primarily plaintiffs' counsel, and to the failure of arbitration panel chairpersons to pressure counsel into taking action on their cases. Finally, the Director noted that the system suffered from a lack of adequate financing resulting in a shortage of personnel. Currently, the average time required for a medical malpractice claim to progress from date of filing to arbitration panel decision is nine to fifteen months in those cases which are actively pressed by the parties' counsel.\textsuperscript{123}

\begin{footnotes}
\item[119.] \textit{Id.} at 312, 385 A.2d at 79.
\item[120.] \textit{Id.} at 312-13, 385 A.2d at 79.
\item[121.] This information and that following was received in response to a questionnaire submitted by the author and answered by Walter R. Tabler, Director of the Maryland Health Claims Arbitration Office.
\item[122.] \textit{Id.} Mr. Tabler did not explain the discrepancy between the 750 cases filed for arbitration and the 619 cases in which arbitration had been completed or was pending. It may well be that those 131 cases represent the 75 to 80 percent of the cases settled before completion of the arbitration panels' review.
\item[123.] \textit{Id.}
\end{footnotes}
Following a decision of the arbitration panel, approximately twenty-five to thirty percent of the cases decided are pursued through litigation in the Maryland courts. The cost per year of the Maryland arbitration system is estimated to be $200,000. According to its Director, the Maryland system is still under constitutional attack in the state's courts. Despite those attacks and despite what he referred to as "obvious shortcomings in the system, some of which currently are the subject of proposed legislative correction," the Director concluded his remarks to the author by stating that "I feel the program basically is accomplishing the purposes for which it was intended." For purposes of comparison and recommendation, which will be developed further, it is interesting to note the results achieved pursuant to a different type of arbitration system currently operating in the Ninth Judicial District of New York. Beginning on February 1, 1980, arbitration panels composed of three attorneys began hearing claims in that District in which the amount of damages sought was $6,000 or less. Following introduction of the mandatory program, civil court calendars were cleared of such cases in a four county area in less than three months time. Trial delays of between nine and sixteen months have been cut from thirty to forty days and forty-two percent of the claims filed are being settled before or during the panel sessions. The system also has been introduced into the Third Judicial District where claim disposition has increased twenty-six percent over that for the same period during the previous year. Although either party may reject the arbitrators' decision and go to trial on the claim, only 8 of the first 200 cases decided by arbitration panels in the Ninth Judicial District were appealed. The system has been judged so effective by New York state court officials that it is going to be expanded to many more counties throughout the state and the jurisdictional limit may be raised to $15,000.

It is not possible, of course, to conclude from the New York experience that mandatory arbitration will be successful in medical malpractice cases. Indeed, the Maryland experience may indicate that it will not be highly successful. The New York arbitration system is obviously limited by its confinement to cases in which damages sought are less than $6,000. Most of those are probably not medical malpractice cases and many may be less complicated and easier to present than malpractice cases. Not all medical malpractice cases need be ex-

124. Id.
125. Id.
126. See text at sections V and VI infra.
128. Id.
tremely complicated, however, and not all involve hundreds of thousands of dollars in damage claims. The Supreme Court of Pennsylvania itself noted in *Mattos v. Thompson* that many of the claims pending under the Pennsylvania Health Care Services Malpractice Act were for $10,000 or less. As a preliminary conclusion, however, even though the New York experience does not offer proof that mandatory arbitration provides an expeditious and just alternative to malpractice litigation, it does indicate that arbitration is successful in some instances and it may indicate potential for success in malpractice situations as well.

Should the Pennsylvania legislature decide that mandatory arbitration is not a suitable alternative to malpractice litigation, it may still consider providing the opportunity to arbitrate malpractice disputes to patients and health care providers who would choose to do so.

IV. AGREEMENTS TO ENTER BINDING ARBITRATION

As previously discussed, some state legislatures have mandated that medical malpractice claimants enter into nonbinding arbitration in an attempt to resolve their claims against health care providers as a condition precedent to bringing such a suit in a court of law. Other state legislatures have enacted laws permitting patients and health care providers to enter into agreements providing that should a malpractice claim arise between them they will submit the dispute to binding arbitration instead of pursuing the action through the courts. Michigan provides an example of the latter type of legislation.

In Michigan, hospitals (which by definition include hospitals, clinics, health maintenance organizations, and sanitariums) are required to offer to patients the opportunity to sign an agreement "to arbitrate a dispute, controversy, or issue arising out of health care or treatment rendered by the hospital." Hospitals are not required to offer the option to patients receiving out-patient diagnostic services only, but are required to offer it to all other patients. Hospitals which do not comply with the Act's requirement may suffer the loss of their malpractice

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129. 421 A.2d at 195.
130. *See* text at sections II and III *supra*.
131. Some states also permit parties to enter into an agreement to arbitrate a malpractice dispute arising between them after the alleged injury has occurred. *See*, *e.g.*, A LA. CODE tit. 6, § 6-5-485 (1975); A LASKA S TAT. § 09.55.535 (Supp. 1980).
133. *Id.* § 600.5040(2)(c).
134. *Id.* § 600.5042(1).
135. Michigan Ins. Bureau Bull. No. 3 concerning the medical arbitration program; provided to the author through the courtesy of the Michigan Insurance Commissioner and her staff.
insurance. It is important, therefore, for hospitals to have documented proof of those instances when they offer agreements to arbitrate to patients which the patients decline to sign. Independent physicians may offer such an opportunity to their patients, although they are not required to do so. Nursing homes and convalescent centers, likewise, are not required to offer the option to their patients.

The Michigan law attaches certain conditions to the offering of the agreement to the patient and to his or her signing it. Execution of the agreement may not be made a prerequisite to care. If a person is being treated in an emergency situation, he or she may be offered the agreement, but such offer may not be made until after the emergency care or treatment is completed. The agreement is revocable by the patient or a representative of the patient within sixty days after execution in the case of a health care provider or within sixty days of discharge in the case of a hospital by notifying the health care provider or the hospital of the revocation in writing. Neither the health care provider nor the hospital is permitted to revoke the agreement. The agreement must contain, in twelve point bold face type directly above the space for the patient's signature, the notice that "This agreement to arbitrate is not a prerequisite to health care or treatment and may be revoked within 60 days after execution [or discharge] by notification in writing."

The patient signing the agreement must be provided with a copy of the agreement and with an information brochure detailing the agreement and the revocation procedures. The agreement remains in effect for one year from the date of execution and may be renewed by execution of a new agreement. Each hospital admission, out-patient surgical treatment, or emergency room visit requires the signing of a new agreement. Nonsurgical hospital/out-patient agreements and physician/patient agreements may cover any treat-

136. Id. See also Michigan Ins. Bureau Bull. No. 1 concerning the medical arbitration program.
138. Id.
140. Id. § 600.5042(1).
141. Id. §§ 600.5041(3), .5042(3).
142. Id. §§ 600.5041(5), .5042(4).
143. Id. §§ 600.5041(6), .5042(7).
144. Id. § 600.5041(4). Although § 600.5041(4) applies to agreements entered into between health care providers and patients and no similar provision exists in the law concerning agreements entered into between hospitals and patients, the law has been interpreted to apply a one year expiration period to the latter type of agreement as well. See American Arbitration Association, Frequently Asked Questions About Arbitration, (pamphlet reprinted from Michigan Hospitals, April, 1976) [hereinafter cited as Frequently Asked Questions].
ment rendered within the one year period. An agreement to arbitrate which includes the conditions required by the Act is presumed valid.

Two cases have been litigated in Michigan on the issue of the sixty day revocation period. In the first, Amwake v. Mercy-Memorial Hospital, where the issue concerned the starting date of the sixty day period, the court held that any revocation must be accomplished within sixty days of discharge from the hospital and that the transfer of a patient from one hospital to another for treatment of a condition arising during the original hospital stay governed by the agreement did not constitute a discharge. The patient's initiation of suit against the first hospital while she was in the second hospital, then, was an effective revocation of the arbitration agreement. By the court's reasoning, the sixty day period had not even begun to run at the time she instituted suit. The court also stated that in the case of an unconscious patient, the sixty day period would not run during the period of unconsciousness and that patients should be given sixty days from the time their disabilities terminate to revoke any arbitration agreement they entered.

In the second case, Capman v. Harper-Grace Hospital, the plaintiff attempted to apply the discovery rule to revocation of the agreement. That is, she attempted to revoke the arbitration agreement not within sixty days of its execution but within sixty days of the time she discovered the alleged injury which prompted her to file suit. The court rejected the plaintiff's argument, stating that while the discovery rule made sense in tolling the statute of limitations where otherwise a patient could suffer a harsh result if he or she were unable to recognize the existence of a potential claim before the running of the statute of limitations, it made no sense in terms of the Malpractice Arbitration Act where no such harsh result would occur. The purpose of the Act is to permit patients to determine before they receive treatment whether they wish to pursue potential malpractice claims by way of arbitration or litigation. Post-discovery revocation simply does not advance the purpose of the Act. The court did recognize that a dif-

149. Id. at 552, 285 N.W.2d at 372.
150. Id. at 553, 285 N.W.2d at 373.
151. 96 Mich. App. at 516-17, 294 N.W.2d at 208.
ferent rule would be applied if the patient were physically or mentally incapable of revoking the agreement within the sixty day period.\textsuperscript{152}

Maine also has legislation permitting patients and health care providers to enter into agreements to arbitrate medical malpractice claims.\textsuperscript{153} In terms of revoking the agreement to arbitrate, Maine allows patients receiving treatment from a hospital to revoke the agreement within thirty days after discharge and those receiving treatment from physicians to revoke within sixty days of execution of the agreement.\textsuperscript{154} Like Michigan, Maine does not permit hospitals to revoke the agreement, but, unlike Michigan, the Maine legislation does permit physicians to revoke the agreement within sixty days of execution.\textsuperscript{155}

In Michigan, medical malpractice arbitration proceedings are conducted by an arbitration association without charge to the claimant. The administrative expense of each case is $200 per party and the claimant's share of the expense is borne by the arbitration administration fund established under the insurance code or by the respondent parties.\textsuperscript{156} Each arbitration panel consists of three members: an attorney, who serves as the chairperson of the panel; a physician, preferably but not necessarily from the respondent physician's specialty; and a person who is not an attorney, a licensee of the health care profession involved, or a representative of a hospital or insurance company. If a case is brought against a hospital only, a hospital administrator may be substituted for the physician panelist; if the case involves a health care provider other than a physician, a licensee of the health care profession involved will be substituted for the physician panelist.\textsuperscript{157} The parties are provided with lists of qualified arbitrators in each of the categories and are given the opportunity to strike from the lists the names of persons they find objectionable. The association selects the final arbitrators from the first candidate mutually agreeable to the parties from each list. If after a second circulation of such lists the parties are not able to agree on a set of arbitrators, the remainder of the panel shall be chosen by the association, subject to strike by the parties.\textsuperscript{158} The parties are not bound by the list of arbitrators circulated by the association and may mutually agree upon a panelist not suggested by the association.\textsuperscript{159}

\textsuperscript{152}Id.
\textsuperscript{153}Me. REV. STAT. tit. 24, §§ 2701-2715 (Supp. 1980).
\textsuperscript{154}Id. § 2702.
\textsuperscript{155}Id.
\textsuperscript{156}MICH. COMP. LAWS ANN. § 600.5044(1) (Supp. 1980).
\textsuperscript{157}Pub. Act No. 38, § 1, 1980 Mich. Legis. Serv. (West) (to be codified in MICH. COMP. LAWS ANN. § 600.5044(2)).
\textsuperscript{158}MICH. COMP. LAWS ANN. § 600.5044(3), (4), (5) (Supp. 1980).
\textsuperscript{159}Id. § 600.5044(6).
A different form of arbitrator selection occurs in South Dakota, which also employs a system where patients and health care providers are permitted to enter agreements to arbitrate malpractice claims. In South Dakota, there is established a health care services arbitration panel for each congressional district. The presidents of the state bar, state medical, and state hospital associations each choose twelve of their members within each district to serve as arbitrators for three year terms. The parties choose two arbitrators (for example, an attorney and a physician) to hear their case; the two chosen arbitrators or the court chooses a third. The South Dakota system raises an interesting question of bias. As noted earlier, there have been challenges to arbitration systems on the basis that the physician member of the panel will be biased against the patient. It appears that in South Dakota the system has built in a possible pro-establishment bias. That is, since not all health care providers will choose to belong to their state professional organizations, will attorneys and physicians who do belong to such organizations be biased against those who do not?

161. Id. § 21-25B-4.
162. Id. § 21-25B-13.
164. The hypothetical situation suggested by the South Dakota arbitration system raises an issue somewhat analogous to that decided by the Supreme Court in Gibson v. Berryhill, 411 U.S. 564 (1973). There, a group of licensed optometrists who were not members of the Alabama Optometric Association, the state professional organization of optometrists, were charged by the Association with unprofessional conduct. The charges of unprofessional conduct were to be heard by the Alabama Board of Optometry, all members of which, by law, were members of the Alabama Optometric Association. Prior to the Board hearing, those optometrists charged filed a complaint in a federal district court seeking an injunction against the hearing primarily on the ground that the Board was biased and could not provide to the optometrists a fair and impartial hearing in accordance with due process of law. The district court agreed with the optometrists and granted the injunction. On appeal, the United States Supreme Court affirmed the district court's reasoning that "the pecuniary interest of the members of the Board of Optometry had sufficient substance to disqualify them" from hearing the unprofessional conduct charges. Id. at 579.

Although the question raised by the South Dakota malpractice arbitration procedure is similar to that presented in Gibson, in that arbitration panel members are also members of their respective state professional organizations while those whose cases they hear may not be, the ultimate issue to be decided in the case is sufficiently dissimilar to allow the conjecture that if the South Dakota situation were to be litigated, Gibson would not be decisive to its resolution. In Gibson it was clear that if all Alabama optometrists not members of the state professional organization were to be found guilty of unprofessional conduct, and accordingly stripped of their licenses to practice, the number of optometrists in the state would have been reduced from 192 to 100. The increase in the optometric business per optometrist occasioned by the drastic decline in the number of optometrists
all likelihood, such a challenge would suffer the same fate as those challenging physician membership on the panels in general. Without an actual showing of bias against a physician who chooses not to be a member of his or her state professional organization, the court probably would not order a new hearing before a different panel or change the panel membership.

Michigan law provides: "A party to the arbitration agreement may demand arbitration of a claim and the proceeding shall be instituted as provided by rule of the association. . . ." 165 The language "A party" indicates that arbitration may be instituted by a health care provider or a hospital as well as by a patient. It must be noted, however, that the arbitration agreement does not apply to disputes over charges for services rendered. 166 In cases involving common questions of law and fact, if separate arbitration agreements exist between a plaintiff and a number of defendants, or between defendants, all of the disputes may be consolidated into one arbitration proceeding. 167 A person who is not a party to the arbitration agreement may join the arbitration at the request of any party and each party to the arbitration is bound by the joinder of the new party. 168

After the appointment of a panel of arbitrators, the parties may conduct discovery as if the matter were any civil action pending before a

would obviously have benefited those optometrists who were members of the state professional organization. Since only such members could serve on the Alabama Board of Optometry, those Board members would be among the likely recipients of the increased business. The potential pecuniary interest of the Board members in the unprofessional conduct decision, therefore, was obvious. No such pecuniary interest is evident in the hypothetical South Dakota situation. It is possible that were a South Dakota physician who was not a member of the state professional organization to be found liable in malpractice, his or her practice might decline and a member of the state professional organization might benefit from any patient's choosing not to frequent that physician. Such could also be the case, however, were a physician who was a member of the state professional organization to be found liable in malpractice. And, in either case, the physician's patients could choose to seek treatment from a physician not a member of the state professional organization. Furthermore, the issue facing the arbitration panel is not action which would result in the deprivation of a physician's license to practice medicine but rather the potential malpractice liability of the physician. The only substantial repercussion of such a decision on the members of the state professional organization would be that the medical malpractice insurance premiums of all physicians might rise. The possibility of such an occurrence has generally been rejected as a ground for disqualifying a health care provider from sitting on a medical malpractice arbitration panel. See, e.g., State ex rel. Strykowski v. Wilkie, 81 Wis. 2d 491, 515-16, 261 N.W.2d 434, 445-46 (1978).

165. MICH. COMP. LAWS ANN. § 600.5046(1) (Supp. 1980).

166. This provision is clearly stated on the arbitration agreements entered into between patients and health care providers or hospitals.

167. MICH. COMP. LAWS ANN. § 600.5046(3) (Supp. 1980).

168. Id. § 600.5046(4).
trial court. The hearing before the arbitrators shall be informal, but parties are entitled to be represented by counsel, to present evidence, to testify, and to cross-examine any witnesses. The panel may call a neutral expert on its own motion and such expert shall be subject to cross-examination by the parties. The panel may order the submission of briefs by the parties within thirty days after the close of the hearing, and it shall render its decision within thirty days after the close of the hearing or receipt of briefs.

South Dakota, again, provides an interesting variation on the panel hearing procedure. South Dakota arbitrators conduct a bifurcated hearing. The first phase of the hearing is limited to questions of liability. If the panel finds that one or more defendants are liable to the plaintiff, there is imposed a thirty day waiting period during which time the parties may attempt to settle the issue of damages. If there is no settlement, the panel reconvenes at the end of the thirty day period and makes a determination as to damages.

Alaska, too, provides an interesting variation in terms of expert testimony. Unlike Michigan, where panelists may call a neutral expert to testify during the proceedings, in Alaska, the arbitrators are authorized to refer the matter before them to an advisory panel which will provide expert advice on the medical facts of the case.

In Michigan, a majority of the panel arbitrators may grant any relief "deemed equitable and just," including money damages or provision for hospitalization, rehabilitation, or support services. The award must be in writing and should include a determination of all questions submitted to the panel the resolution of which is necessary to determine the dispute. The panel must also render a written opinion setting forth its reasons for its determination of liability or nonliability and for the type and amount of award entered. In instances where liability is found and there are two or more health care provider respondents, the panel must also determine the degree of liability of each respondent and must apportion damages between or among them.

Because the Michigan system is one of binding arbitration, appeal to

\[169. \text{Id. § 600.5048(1).} \]
\[170. \text{Id. §§ 600.5043(1), 5050(1).} \]
\[171. \text{Id. § 600.5050(6).} \]
\[172. \text{Id. § 600.5054(2).} \]
\[173. \text{Id. § 600.5054(3).} \]
\[174. \text{S.D. Codified Laws § 21-25B-21 (1979).} \]
\[175. \text{Id.} \]
\[176. \text{Alaska Stat. § 09.55.535(i) (Supp. 1980).} \]
\[178. \text{Id. § 600.5054(4).} \]
\[179. \text{Id. § 600.5055(1).} \]
\[180. \text{Id. § 600.5055(2), (3).} \]
the courts following a panel decision is very limited. A court may
vacate an arbitration panel award only where the award was procured
through fraud, corruption, or undue means; where an arbitrator was
partial or corrupt or the arbitrators committed an act of misconduct
prejudicing the rights of any party; where the arbitrators exceeded
their power; or where the arbitrators refused to postpone the hearing
upon reasonable cause, refused to hear evidence relevant to the con-
troversy, or otherwise conducted the hearing in a manner prejudicial
to the rights of the parties. If the court does vacate the award, it
may order a new hearing before a different set of arbitrators or by the
court. If the award is vacated on the basis that the arbitrators exceed-
ed their authority or conducted the hearing in a manner prejudicial
to the parties, the court may order a rehearing before the same panel of
arbitrators. If the motion to vacate is denied, the court shall confirm
the award. The court may also modify or correct an award on the
basis that the award contains a miscalculation of figures or mistaken
description of persons or property, that the arbitrators have made an
award upon a matter not submitted to them and any modification may
be made without affecting the merits of the issues submitted, or that
the award is in an imperfect form. Following a modification or correc-
tion of an award, the court shall confirm the award as so modified or
corrected.

To date, no Michigan appellate court has ruled on the constitutionali-
ty of the Michigan medical malpractice arbitration system. The trial
courts have divided on the issue with two holding it to be constitu-
tional and a third holding it to be unconstitutional because the
presence of a physician on the panel violates the due process rights of
the plaintiff.

The author has no figures on the actual percentages of patients in
Michigan who are signing agreements to arbitrate their potential
medical malpractice claims. In April, 1978, however, it was estimated
that sixty to eighty percent of all patients who were offered the oppor-
tunity to sign such an agreement were doing so. Figures are

182. Id. § 769.9(3).
183. Id. § 769.9(4).
184. Id. § 769.10.
185. Malek v. Jayakar, Civ. Action No. 78-802-604-NM (Wayne County Cir. Ct.,
February 5, 1979); Pipper v. DiMusto, Civ. Action No. 76-8188-NM (Macomb County Cir.
Ct., August 30, 1977).
186. Manuel v. Pierce, Civ. Action No. 79-929809-NM (Wayne County Cir. Ct., July 14,
1980).
available on the operation of the arbitration system following institution of arbitration actions.\textsuperscript{188} Between January 1, 1976, the inception date of the program, and September 30, 1980, 232 claims for arbitration had been filed. Over two-thirds of those cases had been filed subsequent to January 1, 1979. The Michigan Insurance Commissioner's staff believes that the acceleration in filings is due to the running of the statute of limitations of actions arising after the inception of the program and the court enforcement of arbitration agreements.\textsuperscript{189}

Of the 232 cases filed prior to September 30, 1980, 71 had been closed by that date: 20 were withdrawn by the patient prior to a panel hearing; 34 were settled by the parties prior to a hearing with the amount of settlement ranging from $363 to $220,000; 15 had been decided by arbitration panels with 12 verdicts in favor of respondents and 3 in favor of plaintiffs with the awards in the latter ranging from $750 to $20,000;\textsuperscript{190} and 2 were dismissed by the panels on procedural grounds. On September 30, 1980, there were 161 cases pending for arbitration. The Commissioner's staff indicated that these 161 cases do not represent a "backlog" in the system for several reasons. Eighteen of the cases were being held in abeyance at the request of the parties or by order of the court and fifteen others were scheduled for hearing at that time. A large number of the cases had been filed within the previous two years. The parties are guaranteed six months to complete discovery; most use the entire six months and some then obtain extensions. Finally, the Commissioner's staff noted, there is some "stalling" on the part of the parties pending final appellate court resolution on the issue of the constitutionality of the system.\textsuperscript{191}

The average time required for those cases actually being heard by a panel from the date of filing a claim to final determination by the arbitrators is thirteen months. Seventy-six percent of all cases closed, however, have been settled or withdrawn by the parties prior to panel determination. As of September 30, 1980, no cases were being pursued through litigation following a panel decision. There is no taxpayer ex-

\textsuperscript{188} The following information was gathered in response to a questionnaire submitted by the author to the Michigan Commissioner of Insurance and answered by Randy Watkins, Coordinator of the Medical Arbitration Program for the Insurance Bureau, and Michael Arford, Director, Michigan Medical Arbitration and Health Services, American Arbitration Association.

\textsuperscript{189} \textit{Id.}

\textsuperscript{190} \textit{Id.} It is impossible to tell from these figures whether parties in cases with stronger positions for plaintiffs are more likely to settle before a hearing by the arbitration panels or if plaintiffs simply fare better in settlement proceedings than they do before the panels.

\textsuperscript{191} \textit{Id.}
Alternatives to Medical Malpractice Litigation

pense involved with the Michigan medical malpractice arbitration system because it is funded by assessments against malpractice insurance carriers. While the Commissioner's staff members could not estimate any costs savings to the state promoted by the use of arbitration rather than traditional civil litigation, they theorized that it may be "substantial." The bases for the staff's belief were that the average arbitration hearing has consumed only 2.1 day's time and has cost, on the average, only $1,638.\textsuperscript{192} A member of the Commissioner's staff concluded his information to the author by stating:

As more cases are closed through the arbitration process, the available data on these cases is beginning to indicate that the arbitration system has the potential to accomplish the objectives for which it was instituted. That is to say, a faster resolution of claims, and at lower costs, while providing a fair resolution to all parties.\textsuperscript{193}

In addition to mandatory, nonbinding arbitration, and voluntary, binding arbitration, some states have enacted a third alternative to malpractice litigation: the medical malpractice review panel.

V. MEDICAL MALPRACTICE REVIEW PANELS

At least eighteen states currently have in operation panels which review medical malpractice claims before those claims are adjudicated by a civil court. The state systems vary widely in terms of panel composition, panel duties, type of decision rendered, and court review. No attempt will be made here to outline all of the different features of each system operating in each state. Rather, an examination will be made of Tennessee's Medical Malpractice Review Board and Claims Act of 1975\textsuperscript{194} as representative of medical malpractice review panels in general. Some reference will be made as well to other review panel systems which differ significantly from the Tennessee system and are worthy of note either because of the extremity or the importance of their diversity.

The Tennessee Act, which became effective on July 1, 1975, requires that when a medical malpractice action is filed in any court the judge shall refer the case to the medical malpractice review board for review.\textsuperscript{195} The parties may agree to waive the referral to the board.\textsuperscript{196}

\textsuperscript{192} Id.
\textsuperscript{193} Id.
\textsuperscript{194} TENN. CODE ANN. §§ 29-26-101 to -121 (1980).
\textsuperscript{195} Id. § 29-26-104(b) (1980). Some states require that a malpractice action be submitted to a medical malpractice panel for review prior to being filed with the court. See, e.g., MONT. CODE ANN. § 27-6-301 (1979); NEV. REV. STAT. § 41A.070 (1977); N.M. STAT. ANN. § 41-5-14(D) (1978).
\textsuperscript{196} TENN. CODE ANN. § 29-26-104(b) (1980).
Unless both the claimant and the provider stipulate, however, that board review will not facilitate disposition of the action and unless they both waive board review, no medical malpractice action may be tried by a court without a hearing on the claim's merits before the review board.197

The Act provides for the establishment of a medical review board in each of three "grand divisions" within the state.198 Each grand division contains a master panel from which the individual boards are drawn.199 The master panel is composed of a list of attorneys licensed to practice in Tennessee, submitted by the Tennessee Bar Association; a list of physicians, divided by specialty, licensed to practice in Tennessee, submitted by the Tennessee Medical Association; a list of health care providers submitted by "[a]ll appropriate state professional organizations"; and a list of sixteen persons representative of the general public, none of whom are attorneys, or health care providers or have connections with the insurance industry, appointed by the governor with the approval of the speakers of the state senate and the state house of representatives.200 All persons so named shall serve four-year terms as review board panelists.201 Panels generally consist of three members: an attorney, a health care provider, and a member of the general public.202 Panelists are chosen by the executive director of the board and are selected for service in the order in which their names appear on the various lists.203 In the event of a question as to the specialty of the physician/respondent or of a disagreement by the parties concerning which health care provider should participate in the review, the decision of the director, after consultation with an officer of the Tennessee Medical Association or another appropriate professional organization, is final.204 If the malpractice claim concerns a health care provider other than a physician, the director shall select an additional panelist from the appropriate category of health care provider to serve on the board. If multiple health care providers are involved in the claim, the director shall select an additional person from each health

197. Id. § 29-26-113(a). The Tennessee Act has been held to be applicable to cases brought pursuant to the diversity jurisdiction of the federal courts sitting in Tennessee, Flotemersch v. Bedford County Gen. Hosp., 69 F.R.D. 556 (E.D. Tenn. 1975), although parties may agree to waive board review in federal actions just as they may in state actions, Cline v. Richards, 455 F. Supp. 45 (E.D. Tenn. 1978).


199. Id. § 29-26-108.

200. Id. §§ 29-26-108(1)(A)-D.

201. Id. § 29-26-109(4).

202. Id. § 29-26-107.


204. Id. § 29-26-108(3).
care provider category involved but none of the original board members (that is, attorney, physician, citizen) shall be removed from the panel. Although the parties do not play a direct role in choosing the panelists who make up the review board, they are provided with the opportunity to voir dire the panelists in writing prior to the hearing on the claim. On the basis of the answers to their written questions, the parties may challenge and seek removal of any prospective board members.

Panel composition is one factor involved in medical review boards which varies greatly by jurisdiction. Kansas and Louisiana, for example, have systems in which all voting members of the panels are health care providers. Panels in Massachusetts are composed of one attorney, one physician, and one superior court justice. Panels vary not only by type of panelist, but by number as well. Panels in North Dakota are composed of five members and those in New Mexico of six. Panels in Wisconsin are composed of three members or five, depending upon the amount in controversy and the wishes of the parties.

In Tennessee, board hearings are to be conducted within six months after the parties' pleadings are filed with the board. Any case not heard within one year after the date of the filing of the pleadings with the board shall be referred back to the circuit court for disposition. At least three weeks prior to the board hearing date, the parties shall submit to the director all pertinent written material which will be presented to the board. Board members may have access to the written material prior to the hearing itself. Board hearings in Tennessee are conducted in accordance with the state's Administrative Procedures Act. All parties shall be present or shall be represented by counsel at the board hearings. If a claimant fails to appear at a hearing and does not show good cause for his or her absence, the formal statement of the board shall include the absence as a fact and the presumption that the claim is without merit as a conclusion. If the health care provider fails to appear at the hearing and does not show good cause for the absence, the board's formal statement shall include the absence

205. Id. § 29-26-108(2).
206. Id. § 29-26-111(c).
211. WIS. STAT. ANN. §§ 655.03, .04 (West 1980).
212. TENN. CODE ANN. § 29-26-104(c) (1980).
213. Id. § 29-26-111(b).
as a fact and the presumption that the health care provider has admitted liability as a conclusion.\textsuperscript{215}

The conduct of hearings is another matter in which jurisdictions vary in terms of medical malpractice review panels. In Idaho, for example, parties may attend hearings only at the order of the panel.\textsuperscript{216} In Louisiana, after all of the evidence is submitted to the panel in writing, the parties may convene the panel for the purpose of questioning the panelists.\textsuperscript{217} In Massachusetts, the plaintiff makes an offer of proof to allow the panel to determine whether the plaintiff's claim, if properly substantiated, presents a legitimate question of liability for judicial inquiry.\textsuperscript{218} All panel proceedings in Nebraska and New Hampshire are confidential.\textsuperscript{219}

In Tennessee, within thirty days after the close of the hearing, the board shall notify all parties of its recommendations.\textsuperscript{220} The formal statement of recommendations and/or the minority report of the board, if there is a dissenting minority, shall consist of one or more statements that the evidence supports the conclusion that the defendant failed to comply with the appropriate standard of care as alleged by the plaintiff; that the evidence does not support the plaintiff's allegation that the defendant failed to act with the appropriate standard of care; that there exists a material question of fact, not requiring expert opinion, bearing on liability, for consideration by the court or jury; or that the conduct alleged was or was not a factor in the resulting damages and, if it was, whether the plaintiff suffered any disability or impairment and the extent of that disability or impairment.\textsuperscript{221}

The type of decision rendered by the review board is another area in which states vary in terms of medical malpractice review. Boards in Arizona, Kansas, and New Mexico, for example, consider only the question of liability.\textsuperscript{222} Boards in Hawaii, Idaho, and Rhode Island, at least in certain instances, consider issues of damages as well as liability.\textsuperscript{223} Boards in Massachusetts and Nevada consider only whether the complaint has sufficient merit to warrant judicial review.\textsuperscript{224}

\begin{itemize}
  \item \textsuperscript{215} Id. §§ 29-26-113(b)-(c) (1980).
  \item \textsuperscript{216} IDAHO CODE § 6-1008 (1979).
  \item \textsuperscript{217} LA. REV. STAT. ANN. § 40:1299:47(E) (West 1977).
  \item \textsuperscript{218} MASS. ANN. LAWS ch. 231, § 60B (Michie/Law. Co-op Supp. 1981).
  \item \textsuperscript{219} NEB. REV. STAT. § 44-2846 (1978); N.H. REV. STAT. ANN. § 519-A:8 (1974).
  \item \textsuperscript{220} TENN. CODE ANN. § 29-26-104(c) (1980).
  \item \textsuperscript{221} Id. § 29-26-112(c).
  \item \textsuperscript{222} ARIZ. REV. STAT. ANN. § 12-567(F) (Supp. 1957-80); KAN. STAT. ANN. § 65-4903 (1980); N.M. STAT. ANN. § 41-5-20 (1978).
  \item \textsuperscript{223} HAW. REV. STAT. § 671-15(a) (Supp. 1980) and (b) (1976); IDAHO CODE § 6-1004 (1979); R.I. GEN. LAWS §§ 10-19-6, -7 (Supp. 1980).
  \item \textsuperscript{224} MASS. ANN. LAWS ch. 231, § 60B (Michie/Law. Co-op Supp. 1981); NEV. REV. STAT. § 41A.060 (1977).
\end{itemize}
Once the board in Tennessee has entered its formal recommendations, the parties have thirty days to accept or reject them. If both parties accept the recommendations in writing, a settlement agreement will be prepared and executed by the parties. If either party fails to respond within thirty days, rejection of the recommendations will be presumed. If either party rejects the recommendations or if despite the parties' acceptance of the recommendations no settlement agreement is executed, the claimant may proceed with his or her malpractice claim in the court in which it was originally filed.225

Most states have provisions similar to Tennessee's for rejection of a panel decision and initiation or pursuit of court action. Massachusetts, however, requires the posting of a bond by plaintiffs pursuing a malpractice action in court following a review board decision.226 The Massachusetts bond requirement was held to be constitutional despite allegations that it violated equal protection, due process, and separation of powers principles.227

In Tennessee, no statement or expression of opinion made during the course of a board hearing is admissible into evidence at any subsequent trial of the action.228 The formal recommendations and any minority statement, however, are admissible as exceptions to the hearsay rule.229 The Supreme Court of Tennessee has decided two cases concerning the admissibility of the boards' opinions into evidence at subsequent trials.230 In each, the court recognized the admissibility of the recommendations but made it very clear that the recommendations

227. Paro v. Longwood Hosp., 373 Mass. 645, 369 N.E.2d 985 (1977). There is some evidence that the bond requirement imposed by Massachusetts law reduces the number of malpractice cases pursued through the courts following decision by the Massachusetts Medical Malpractice Tribunals. Results from a survey of cases decided by the tribunals indicated that of 241 cases heard by the tribunals, 101 were deemed sufficient to be filed in court (and, accordingly, no bond was required for filing) and 140 were not (therefore requiring the posting of a bond before filing). Of the 140 in which a bond was required, bond was posted in only 29, thereby eliminating from the courts 79.2 percent of those cases determined by the tribunal to be unworthy of court consideration. (Information cited in a report labeled "House - No. 5631" provided to the author by John A. Iannelli, Administrative Assistant to the Massachusetts Commissioner of Insurance.) A similar bond requirement was held unconstitutional by the Supreme Court of Arizona. Eastin v. Broomfield, 116 Ariz. 576, 570 P.2d 744 (1977).
229. Id. § 29-26-112(d)(2). Prior to July 1, 1980, TENN. CODE ANN. § 23-3409 prohibited any board member from participating at a subsequent trial on the matter either as counsel or as witness. The law currently in effect makes no reference to participation by board members at any subsequent trial.
230. Runnells v. Rogers, 596 S.W.2d 87 (Tenn. 1980); Baldwin v. Knight, 569 S.W.2d 450 (Tenn. 1978).
were no substitute for the expert evidence required of plaintiffs in medical malpractice actions.\textsuperscript{231}

Again, states vary widely in terms of the admissibility of review boards' decisions into evidence at subsequent trials and also in terms of presenting as witnesses the members of the review boards. Louisiana, Nebraska, New Jersey, and North Dakota permit the parties to submit the review panel's opinion as evidence and to call at least some of the panelists as witnesses at trial.\textsuperscript{232} Montana forbids the parties to do either.\textsuperscript{233} Arizona allows the panel's report to be admitted into evidence, but does not permit the parties to call the panelists as witnesses.\textsuperscript{234} Kansas permits the parties to call the board members as witnesses, but does not allow the introduction of the board's report into evidence.\textsuperscript{235}

Although not present in the Tennessee Act, it should also be noted that in several states if a plaintiff prevails before the medical malpractice review board, the board and/or the state medical association is charged with helping the plaintiff to locate an expert witness who will appear on the plaintiff's behalf at trial.\textsuperscript{236}

Between July 1, 1975 and June 30, 1980, 944 cases were filed for review with the Tennessee Medical Malpractice Review Board.\textsuperscript{237} Of the 944 cases, 489 had been reviewed by a board, 105 had been settled prior to review, 232 had been nonsuited prior to review, and 118 were pending for review. The Tennessee official responding to the author's questionnaire stated that the 118 pending cases do not represent a "backlog" in the system. The official stated, however, that at times cases were not heard within the ninety day period allotted for hearing.\textsuperscript{238} Any delay, however, was usually caused by a request for a continuance by the parties or counsel because of conflicting schedules, delay in conducting discovery, or lack of time to allow for preparation of a complex case. Information was not available on the amount of time

\begin{footnotes}
\footnoteref{1}{596 S.W.2d at 89; 569 S.W.2d at 453.}
\footnoteref{3}{MONT. CODE ANN. § 27-6-704(2) (1979).}
\footnoteref{4}{ARIZ. REV. STAT. ANN. § 12-567(M) (Supp. 1957-1980).}
\footnoteref{5}{KAN. STAT. § 65-4904(c) (1980).}
\footnoteref{6}{MONT. CODE ANN. § 27-6-307 (1979); NEV. REV. STAT. § 41A.090 (1977); N.M. STAT. ANN. § 41-5-23 (1978).}
\footnoteref{7}{237. This and following information was gathered in response to a questionnaire submitted by the author to the Executive Director of the Tennessee Medical Malpractice Review Board and answered by an anonymous source [hereinafter cited as Tennessee Questionnaire Response].}
\footnoteref{8}{238. Id. Prior to July 1, 1980, TENN. CODE ANN. § 23-3403(c) provided that panel hearings were to be conducted within ninety days after pleadings were filed with the board. That time limit was extended by amendment and is now six months.}
\end{footnotes}
usually required for a case to pass from time of filing to completion of board review, but the official noted that if board review is not completed within one year of the date of filing the case is referred back to the circuit court with which it was originally filed. Although accurate statistics were not available concerning the number of cases pursued through litigation following a decision by the review board, the Tennessee official indicated that figures from one grand division show a thirty-three percent litigation rate. The medical malpractice review board system is operated at no cost to the taxpayers. Review board operations are funded by the state's health care providers. The annual budget for the system's operation is approximately $100,000 - $125,000, although, the Tennessee official noted, the full amount is not always used.

In looking at results of medical malpractice review boards, it is also appropriate to discuss the results of the review panel system operating in the State of New York. No attempt has been made in this article to discuss the New York system in detail because the system varies within each of New York's Judicial Departments. For example, in the Second Judicial Department, if there are two or more defendants representing different medical specialties, the supreme court justice presiding over the medical review panels in that district may designate two panels so each defendant will be heard by a specialist in his or her own field. In the Third Judicial Department, a panel hearing a case involving a podiatrist must contain a podiatrist and may not contain a physician from any other specialty. In the Ninth Judicial District of the Second Judicial Department, it appears that the panel hearing consists of little more than oral argument by the parties' attorneys. Despite these differences among judicial departments, the New York experience is instructive on the issues of the effectiveness of medical malpractice review panels.

The New York Act was enacted, as were most other such acts, with the intention that it would weed out frivolous medical malpractice claims against physicians, provide a forum for settlement negotiations, and apprise litigants of the strengths and weaknesses of their cases. These actions were intended to result in a decreased number of malpractice suits brought to trial, in lower jury verdict amounts, and

239. Tennessee Questionnaire Response, note 237 supra.
240. The Act establishing New York's medical malpractice review panels may be found at N.Y. JUD. LAW § 148-a (McKinney Supp. 1980).
242. Id. at 12.
243. Id. at 101.
in a lessening of the congestion of civil court calendars by providing pretrial disposition of cases with corresponding savings in time, money, and effort.\textsuperscript{244} In the opinion of the New York ad hoc committee studying medical malpractice, the Act has not accomplished its objectives. It is appropriate here to look at the Ninth Judicial District, the district in which mandatory arbitration seems currently to be operating so effectively,\textsuperscript{245} and at the State of New York as a whole.

In the Ninth Judicial District, between January 1976 and December 1978, 168 panel hearings were held. Of the 168 cases heard, the panel issued recommendations in 84 cases. Of that 84, 21 cases, or 25 percent, were then settled prior to trial. In traditional pretrial conferences held in medical malpractice cases in the district during the same three year period, there were 502 conferences held with 188 cases settled, a settlement rate of 37.4 percent. Furthermore, the average dollar value of those cases settled subsequent to the issuance of a panel recommendation was higher than that reached subsequent to a traditional pretrial conference. Of those cases going to trial following a panel recommendation, the verdicts entered by the courts were generally consistent with the panel determinations. While there appear to be correlations between panel recommendations and subsequent settlements and verdicts, no definitive conclusion concerning such a relationship may be drawn. Because post-panel settlements usually occur immediately prior to trial, there may be many intervening factors, such as changes in the medical or financial positions of the parties, affecting the actual settlement.\textsuperscript{246}

In New York State as a whole between January 1976 and December 1978, 2,041 panel hearings were held resulting in 1,574 panel recommendations. Of the 1,574 recommendations, there were 145 in-panel settlements and 855 pretrial dispositons, representing a combined settlement rate of 63.5 percent. During the same period of time, a total of 3,420 medical malpractice pretrial conferences were held throughout the state resulting in 801 settlements or a settlement rate of 23 percent. Pretrial settlements for non-medical malpractice tort cases during that same period of time, however, averaged over 83 percent, with the settlement rate for motor vehicle cases averaging over 87 percent. Again, medical malpractice settlements reached subsequent to panel hearings were higher in dollar amount than those reached subsequent to traditional pretrial conferences.\textsuperscript{247}

Based on these statistics and others cited in its report, the Ad Hoc

\textsuperscript{244} Id. at 1.
\textsuperscript{245} See notes 127 & 128 and accompanying text supra.
\textsuperscript{246} See N.Y. Report, supra note 241, at 102-03.
\textsuperscript{247} Id. at 140-41, 143.
Committee reached three conclusions concerning the effectiveness of the medical malpractice panels in New York. First, the Committee concluded, the system had not met the legislature's goal of promoting pretrial settlements or of decreasing the number of cases actually being brought to trial. Rather, the Committee concluded, an aggressive pretrial conference conducted by the court in the ordinary course of its business would promote a greater settlement rate than a court encumbered by an additional procedural layer in the form of medical malpractice panels. The cost of the panel system, the Committee noted, is in excess of $400,000 per year, a figure that is quite substantial in light of the panels' questionable performance and the small number of medical malpractice cases which actually occur. Second, the Committee concluded that the system had likewise failed to reduce the total dollar value of medical malpractice verdicts and settlements. Not only has the system not alleviated the problem of excessive verdicts and settlements, the Committee stated, but it has exacerbated it. Plaintiffs who receive unanimous panel decisions are notorious in demanding extremely high settlements and in proceeding to trial. Defendants receiving unanimous panel decisions are rarely willing to even discuss settlement. Finally, the Committee said, New York's medical malpractice review system has failed to provide a structured forum for settlement negotiations. The goal of the legislature to promote settlements at the panel stage has simply not been met. Settlements at the panel stage are rare—approximately 4.3 percent of all cases brought before the panel are settled there—and litigants routinely await a panel recommendation before they even consider settling. Some districts do not even permit settlement discussions as part of the panel process.

The ultimate recommendation of the Ad Hoc Committee was that the panel system be abolished in New York. The current system is counterproductive: it strengthens the resolve of the panel victor to go to trial, it results in more costly settlements, its cost in terms of time and money has exceeded its benefit to the judiciary, the bar, and the public. The system has not solved the medical malpractice crisis, and it raises questions of fairness in a constitutional, procedural, practical, and fiscal sense. Instead of the current panel system, the Committee proposed the adoption of an optional mediation panel system. Pursuant to such a system, the judge assigned to the medical malpractice case would conduct a vigorous pretrial conference making a strong effort to

248. Id. at 160-62.
249. Id. at 162-63.
250. Id. at 163-64.
251. Id. at 165.
252. Id. at 165-66.
get the parties to settle. If the conference was not successful, the parties could then choose to submit their dispute to a mediation panel or could have their case placed on the general court calendar.\footnote{253}

VI. CONCLUSION

In the early and mid-1970's, the nation's health care providers, malpractice insurance companies, attorneys and judges, and consumers found themselves in the midst of a medical malpractice crisis.\footnote{254} The number of medical malpractice claims was escalating; litigation of the claims was clogging the nation's courts; malpractice claimants found that it was taking sometimes as long as several years to reach a resolution of their claims; settlement and verdict amounts were increasing; the premiums health care providers were being forced to pay for malpractice insurance were reaching astronomical sums; some insurance carriers were refusing to provide further malpractice coverage to providers; and some physicians were increasingly practicing defensive medicine or were ceasing to practice medicine altogether. In response to these occurrences, state legislatures began to look for alternatives to traditional malpractice litigation. Ideally, an alternative system of dispute resolution would provide swift, fair resolution of malpractice disputes at less expense in terms of time, money, and energy on the part of all those involved in malpractice litigation.

Pennsylvania was one of more than thirty states to enact legislation to try to deal with the medical malpractice crisis.\footnote{255} The Pennsylvania Health Care Services Malpractice Act mandated that malpractice claimants submit their claims to nonbinding arbitration prior to litigating their cases in court.\footnote{256} After four-and-one-half years of operation, the Supreme Court of Pennsylvania held the system to be unconstitutional on the basis that cases moved through the arbitration system so slowly that claimants were, in effect, being denied their constitutionally guaranteed right to trial by jury.\footnote{257} Despite the fact that the legislature had recently enacted amendments to the original Act and that the Administrator had promulgated new regulations,\footnote{258} both of which were designed to improve the efficiency and effectiveness of the

\footnote{253. \textit{Id.} at 166-67.}
\footnote{254. \textit{See} Berkman, note 1 \textit{supra}; text accompanying notes 1-2 \textit{supra}.}
\footnote{256. \textit{Id.} § 1301.309 (declared unconstitutional, see text accompanying notes 65-77 \textit{supra}).}
\footnote{257. \textit{Mattos v. Thompson, 421 A.2d 190 (Pa. 1980); see} text accompanying notes 65-77 \textit{supra}.}
\footnote{258. \textit{See} notes 14-15, 83 and accompanying text \textit{supra}.}
Pennsylvania system, it has now been transformed into a system of voluntary nonbinding arbitration. There is little hope that many malpractice claimants and health care providers will make use of the arbitration alternative to settle their disputes. Instead, they will return to the courts as a source of dispute resolution. Since there is no indication that the medical malpractice crisis has abated, it is highly probable that the Pennsylvania legislature will attempt to enact new legislation offering another alternative to traditional litigation.

One obvious alternative to the unconstitutional Pennsylvania system would be a mandatory, nonbinding arbitration system such as that in operation in Maryland. That system has, to date, withstood constitutional attack. Statistics available concerning the operation of the Maryland arbitration system are not, however, extremely encouraging. While the settlement rate in Maryland appears to be high — approximately seventy-five to eighty percent — only twenty-three percent of the cases which have been filed for arbitration have been terminated and twenty-five to thirty percent of the cases which have been decided by arbitration panels have then been appealed to the state courts. There are figures available indicating that an arbitration system covering all civil cases where damages sought are less than $6,000 is operating well in parts of New York state. Whether such a system could also operate effectively if limited to medical malpractice cases, which are often complicated to present and which frequently demand money judgments far in excess of $6,000, is unknown. It is probably safe to assume that were Pennsylvania to reenact such a system it would come under quick attack from litigants and would have to prove very efficient and effective from its inception in order to withstand a constitutional challenge.

A second alternative available to the legislature is a system permitting patients and health care providers to enter into agreements to arbitrate any malpractice dispute that may occur between them. Such a system is currently in operation in Michigan. Statistics on the result of the Michigan program are still somewhat inconclusive since it has only been in operation for five years and since only recently has the number of claims begun to accelerate. It can be noted, however, that between January 1, 1976 and September 30, 1980, thirty percent of all claims filed had been resolved and more than twice as many claims had been settled as were tried to a panel. Probably the biggest advantage

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259. See notes 87-108 and accompanying text supra.
260. See notes 109-120 and accompanying text supra.
261. See notes 121-124 and accompanying text supra.
262. See notes 127-128 and accompanying text supra.
263. See generally text at section IV supra.
to a system such as Michigan's is that—because the system is one of voluntary, binding arbitration—cases may be appealed to the courts only in rare instances. Obviously, then, the malpractice burden on the courts would be almost eliminated through the use of such a system. Equally important, however, would be the incentive, or at least lack of disincentive, on the parts of the claimants and health care providers to pursue settlement negotiations. Under a system of binding arbitration, there would be no reason for the parties to delay settlement talks until receiving the decision of the panel. Unlike the situation of nonbinding arbitration or medical panel review, the parties cannot hope to parlay a favorable board decision into a bigger settlement. In a system of binding arbitration, the parties take what they receive.

A final alternative to traditional malpractice litigation is the medical review panel system and in looking at review panel systems the legislature would have a great variety from which to choose. Such a system is in operation in Tennessee and appears to be working relatively well. In the five years in which the system has been in operation, the review panels have disposed of more than eighty-seven percent of the cases filed. The settlement rate, however, has not been high—eleven percent—and there is some indication that at least a third of the cases decided by a panel are then pursued through the courts. A medical review panel also exists in New York. There, not only is the in-panel settlement rate low—nine percent—but also settlements reached following panel decisions are substantially higher than those reached subsequent to traditional pretrial conferences. Furthermore, the panel system actually represents not an alternative to civil litigation but in many instances merely a prerequisite to litigation requiring additional expenditures of time, money, and energy by the parties, their counsel, and the legal system. It has been recommended by the Ad Hoc Committee studying the New York system that medical review panels be abolished and be replaced by an optional mediation system.

No system which a state adopts as an alternative to malpractice litigation will be perfect. Any will take a great deal of organizational and administrative effort by state officials which must then be followed by cooperation from the parties and their counsel. On the whole, however, it appears that the system most likely to achieve the results sought in an alternative to malpractice litigation—dispute resolution which is relatively quick and fair to the parties and nonburdensome to the courts—is voluntary binding arbitration. Such a system would not be immune to challenge, however. Legislation establishing such a

264. See notes 194-239 and accompanying text supra.
265. See notes 240-253 and accompanying text supra.
system must go to great lengths to insure that patients entering into such agreements understand what they are doing, that the contracts they sign are not contracts of adhesion, that health care providers cooperate by offering to enter such agreements with patients and, that the arbitration system really does operate quickly and fairly for all parties. The Michigan legislation and the Michigan system offer examples, however, which should be instructive for any legislature seeking a viable alternative to traditional medical malpractice litigation. It is certainly worthy of consideration in Pennsylvania.

266. See generally text at section IV supra.