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Committee on Insurance (AC-In)

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Perspective

*457 COMPULSORY ARBITRATION: AN INSTRUMENT OF MEDICAL MALPRACTICE REFORM AND A STEP TOWARDS REDUCED HEALTH CARE COSTS?

David B. Simpson [FNa]

The sharply escalating cost of health care in the United States, and particularly the disproportionate share of gross national product that it consumes in comparison with the experience of other advanced industrialized societies, is the subject of increasing attention, and justified concern. Health care costs in the United States will rise from $839 billion in 1992 to a projected $940 billion in 1993, and now consume 14 percent of gross national product (GNP). [FN1] In 1965, the nation spent only 6 percent of the GNP on health care. [FN2] The figure had risen to 9.3 percent by 1980, and observers believe we are headed towards spending 20 percent or more of the GNP on health care if present trends continue. [FN3] Annual spending per capita rose, in constant dollars, from $950 in 1970 to $2350 in 1989. [FN4] In comparison, other major industrialized countries spend between 6 percent and 10 percent of their GNP on health care. [FN5]

Obviously, this has created a search for the sources of the problem. Some of that search may have taken on aspects of a witch-hunt, inordinately focusing on "medical malpractice" or, more precisely, the process for resolving claims of medical malpractice and compensating persons injured thereby. This is not *458 to say, as some interest groups, such as trial lawyers, seem almost reflexively inclined to do, that the existing system does not warrant examination, and may not bear improvement.

To the contrary, as part of any endeavor to rationalize the delivery of health care and reduce overall costs, attention should be directed to existing methods for responding to claims for medical malpractice. Malpractice claims obviously affect the cost of health care services, at several levels and both directly and indirectly, by increasing the costs directly attendant to the existing claims disposition process and through increased professional liability insurance premiums resulting from such recoveries. This eventually translates into increased charges to consumers through additional fees for added testing, diagnostic services and other procedures employed defensively, without medical necessity, to protect against prospective malpractice claims.

The present system for addressing medical malpractice claims subscribes to a traditional litigation mode involving extensive and expensive pre-trial discovery, protracted delays until trial or settlement, and the use of lay jurors inexperienced in the practice of medicine. These jurors are charged with the task of determining actionable "fault" under applicable negligence standards. The nature of the litigation process, and the composition of the typical lay jury, operate to produce damage awards in an economic vacuum, without reference to, or appreciation of, the effects of excessive recoveries upon the economics of the health care system. [FN6] And there is the potential for excessive and irrational awards for non-objective injuries such as pain and suffering, or for punitive damages.

At the outset, however, it must be emphasized that it would be both irresponsible and counter-productive to approach the critical issue of medical malpractice reform from factually inaccurate preconceptions, or from the perspective of a partisan or ideological

*459 agenda which has objectives other than improved health care and cost control. [FN7] Much of the public discussion, and some of the more extravagant proposed correctives, may suffer in this respect. Unsupportable claims have been made that proliferating malpractice litigation and increasing recoveries are entirely, or substantially, the product of a legal system that allows contingency fees. In this vision, but for greedy and irresponsible plaintiffs' attorneys who constantly foment meritless litigation, the problem would largely dissipate.

When the Bush Administration finally produced its first health-care initiative, in May 1991, the emphasis was upon controlling what it called "the fastest-rising part of medical costs--malpractice litigation and the insurance to cover it." [FN8] The proposal involved encouraging states to adopt limits on the amount that malpractice victims could recover for pain and suffering, and setting up mediation systems for resolving disputes. [FN9] States failing to comply would lose some of the federal funding currently available to them under the Medicare and Medicaid system. [FN10]

While medical malpractice insurance premiums have risen *460 faster than other components of the health care system, [FN11] the overall impact of insurance premiums on the nation's almost one trillion dollar health care budget must be placed in perspective. Although total expenditures on malpractice insurance by doctors and hospitals rose a hundred-fold from $60 million in 1960 [FN12] to $5.6 billion in 1991, [FN13] total malpractice premiums have not risen appreciably faster than have expenditures on the health care system as a whole. Additionally, the premiums for 1991 did not equal even one percent of total health care expenditures for that year, although representing a substantially higher percentage of the total amount expended directly on physicians' services. [FN14]

This is not to suggest that the amounts paid for liability insurance are not, in absolute terms, meaningful, nor that premiums have not escalated dramatically for certain high-risk categories of medical practice to amounts which, in absolute terms, are very material. However, the average doctor's malpractice insurance premium in 1985 was only $15,000, [FN15] not the $200,000 paid by neurosurgeons and obstetricians practising in Miami, Florida, in that year, [FN16] nor the $150,000 annual premium paid in 1991 by neurosurgeons practicing in Chicago. [FN17]

Usually lost in the discussion about the amounts paid for liability insurance premiums, because far more difficult to quantify, but clearly more important as a component of total health care expense, is the cost of "defensive medicine." Defensive medicine is made up of the redundant or superfluous diagnostic tests and and treatment procedures employed to ward off charges of medical *461 malpractice. In assessing the relationship between rising health care costs and the medical malpractice claims disposition process, the influence of "defensive medicine" may be of greatest significance. There is, however, considerable dispute as to the amount actually at issue. The American Medical Association has put the cost of defensive tactics at $15 billion, [FN18] an insignificant amount in an almost one trillion dollar total health care budget. [FN19] Another source has estimated the cost at between 15 percent of the cost of physician services and 30 percent of the total cost of health care. [FN20]

The litigiousness of patients, allegedly inflamed by contingency-fee lawyers, is also far less clear than would be supposed from some of the discussion, as is any assumption that malpractice suits filed are, disproportionately in relation to other types of claims, without merit. A recent study by observers at Harvard Medical School commented that "the frequency of malpractice claims among patients injured by medical malpractice has been the subject of much speculation and little empirical investigation." [FN21] That study went on to conclude that far more people are injured than ever bring suit. [FN22] The study found that only a small fraction of patients who suffered disabling injuries from the negligence of doctors or other health care providers ever filed a tort claim, and noted that less than half of these claims produced a settlement or award. [FN23] Specifically, less than 2 percent of patients injured by medical negligence in a large number of cases studied in New York ever filed malpractice suits. This would suggest that, contrary to popular assumption, the recent growth in medical malpractice litigation has served only

to narrow the truly wide gap between actual negligently-caused injuries and successful suits for compensation, and not to overshoot that gap. [FN24]

***462** The assumption that juries are automatically more generous towards plaintiffs than are other fact-finders is also open to question. According to a study of a random group of federal court cases over a five-year period, plaintiffs litigating medical malpractice claims before juries won their cases in only 29 percent of the cases studied, compared to a 50 percent success rate for those whose cases were heard by a judge. [FN25] In addition, the average dollar amount of recovery was reported to be slightly higher in non-jury trials. [FN26]

Another study of malpractice cases in New Jersey indicated that juries found for medical defendants about two-thirds of the time. [FN27] Of equal interest, doctors won verdicts in about half of the cases which a physician-run insurance company's peer review found nondefensible. [FN28]

Such challenges to much of the popular wisdom about the infirmities of the dispute resolution process, particularly as it is employed to deal with claims of medical malpractice, do not obviate the need for a reexamination of the process with a view to possible reform. Given the astronomical cost of health care in absolute terms, and the fact that it is increasing faster than either the inflation rate or population growth, no aspect of it may responsibly be treated as "off limits." [FN29] Paradoxically, the "revisionist" studies may serve to reinforce, rather than detract from, the cause of reform. [FN30] For if the costs (direct and indirect) of the present system are considered too burdensome, consider the implications. The burden would be crushing, in terms both of health care costs and strain on a judicial system already ***463** overburdened, if injured parties were to come forward in vastly increased numbers to pursue, through the existing litigation process, legitimate, but heretofore neglected, claims. And, since trials before judges, as before lay jurors, are conducted subject to the same existing definitions of fault and legal principles and standards governing the award and calculation of damages, question concerning the continuing utility of these rules, would not be resolved merely by avoiding jury trials. The point is that the need for reform is far too important to for the case to be made through the falsification or manipulation of data, rhetorical extravagances, or by defining the issues to serve predetermined and discrete ideological or political objectives. A legitimate solution which commands the necessary degree of broad-based public support will only come through an honest and candid confrontation of the realities, including an honest acknowledgment of what interests will be affected by any changes. [FN31]

The interests of employers, insurers, welfare plans, physicians and other health-care providers are all caught up in the problem of escalating health care costs. So, too, are the federal, state, and local governments which collectively pay a substantial portion of the nation's health care bill. There should be sufficient community of interest among these groups to implement, if empirically shown to be useful, legal reforms concerning medical malpractice claims, even if the creation of a consensus for other types of health-care reform proves more elusive. What is missing for the moment is a sustained effort on the part of public officials, business executives and labor leaders to transform this community of interest into responsible and tangible reform initiatives.

The replacement of the existing litigation process with a suitable alternative dispute resolution methodology may contribute significantly to an amelioration of rising health care costs, even absent the implementation of the many other types of reforms ***464** in the health delivery system which are presently being discussed. Moreover, an arbitration system designed to provide for the fair, expeditious and efficient handling of medical malpractice claims may represent a significant improvement in the dispute resolution methodology applicable to malpractice claims, apart from its potential for reducing overall health care costs. Many states have strong judicial and legislative policies favoring arbitration over litigation as a means of settling disputes, including disputes arising out of medical malpractice claims. [FN32] Arbitration is generally seen as not only less expensive, but also more expeditious than litigation, and as contributing to relieving the serious congestion that most court systems are experiencing.

An alternative dispute resolution methodology could allow doctors and hospitals treating patients to require, as a condition to treatment, that patients enter into written agreements to submit malpractice claims to binding arbitration. [FN33] This procedure would obviously be inapplicable to patients seeking treatment under circumstances where they would not be deemed competent to give their informed consent, such as those being treated on an emergency basis. Health insurance programs could impose a similar requirement as a condition of enrollment. The procedure would also be applicable to minors receiving treatment, whose parents or other legal guardians could grant the necessary consent.

Most states today have enacted statutes which generally allow parties to agree to arbitrate disputes, and make such agreements, and any resulting arbitral awards, judicially enforceable. The Federal Arbitration Act [FN34] also enforces agreements to arbitrate. ***465** This Act, however, is limited in its application to arbitration provisions incorporated into contracts involving interstate commerce. [FN35] Contracts governing the delivery of health care either by individual providers or through membership in health maintenance organizations (HMOs) could be deemed to fall within the purview of the federal statute. Whether this circumstance would suffice to override existing state law impediments to arbitration of malpractice claims is a question yet to be definitively resolved. A physician's claim of wrongful exclusion from local hospital privileges has recently been held by the United States Supreme Court to involve a transaction affecting interstate commerce sufficient to fall under the jurisdiction of the federal anti-trust laws; [FN36] and the Federal Trade Commissions is examining the anti-competitive aspects of self-regulation by medical groups including health-care regulatory boards. [FN37] Such intrusion into an area traditionally perceived as intra-state in nature could portend similar determinations as to at least some provider contracts or relationships.

Any proposal entailing the extensive use of arbitration should contemplate that arbitrations would be conducted by arbitrators drawn from panels of persons who have both expertise and independence. It is essential to public acceptance of this procedure that the arbitrators not be perceived to be creatures of, or to be coopted by, any interested constituency, especially not that of health care providers or of medical insurers. One of the challenging aspects of any reform proposal is to identify appropriate sources from which arbitrators of sufficient independence can be selected.

As a general proposition, the ability to make a legally enforceable agreement to arbitrate generally depends on the capacity of the parties to enter into a legal agreement and to sue and be sued. So long as a party has a general legal capacity to contract with respect to the matter in dispute, either in his own right or in a legally recognized representative capacity, he can bind himself or the party he represents to arbitrate all disputes arising ***466** therefrom. [FN38]

A related issue involves the possible elimination or modification of certain types of damage awards in respect to medical malpractice claims. The existing system has been extensively criticized because, in many jurisdictions, there are no limitations on the amounts that may be awarded for pain and suffering or punitive damages. Critics of the present system contend that jurors are thus given carte blanche to indulge their sympathies for injured individuals entirely divorced from objective standards for the measurement of the injuries or for appropriate financial redress. Also, jurors are claimed to be essentially unconcerned with the larger effect of individually over-generous awards on the overall costs and economics of the health care system, and are not even permitted to be informed about such matters. There is also question as to whether punitive damages, which are designed to penalize the culpable wrongdoer, are properly awarded in many cases, especially where society as a whole, through elevated health care costs, ultimately bears the economic burden.

Although less clear than is the right to incorporate a mandatory arbitration provision into contracts for the provision of medical services, it may be possible to incorporate specific limitations on the amounts or types of damages that may be awarded for a health provider's negligent or otherwise substandard performance of his duties. It would clearly be inappropriate and against public policy to allow health providers to disclaim their

liability for negligence and any contract purporting to do so would surely be unenforceable (at least as to such a clause). It is far less certain, however, that agreements placing limitations on the dollar amounts of damages recoverable, such as for economically ***467** non-quantifiable claims for pain and suffering, would, or should, be deemed equally offensive to public policy. They should not be, so long as any such restrictions do not constitute an unconscionable curtailment of an injured patient's right to be made whole for measurable economic loss. In many types of commercial agreements parties are permitted to agree to significant limitations on the kinds and amounts of damages recoverable for breaches of contractual obligations. It is, for example, very common to exclude consequential damages such as lost profits, even though doing so necessarily limits the defaulting party's financial liability and, conversely, the claimant's right to be compensated for his losses and damages.

The use of the arbitration process should provide a means for curtailing the award of punitive damages in connection with arbitrated malpractice claims. In many, although not all, American jurisdictions, arbitrators are without power to grant punitive damages, even when the parties agree. [FN39] Punitive damages have been called a "sanction reserved to the State," and "this is a public policy of such magnitude as to call for judicial intrusion to prevent its contravention;" thus, "since enforcement of an award of punitive damages as a purely private remedy would violate strong public policy, an arbitrator's award which imposes punitive damages should be vacated." [FN40] If arbitrators were allowed to award punitive damages, courts would find it necessary to review arbitrators' decisions for abuse of discretion, since, "under common-law principles there is eventual supervision of jury awards of punitive damages, in the singularly rare cases where it is permitted, by the trial court's power to change awards and the appellate court's power to modify such awards." [FN41] Such required supervision of arbitrator's awards would run afoul of a basic purpose of arbitration--the avoidance of judicial review. If, notwithstanding, it were considered important in a malpractice scheme dealing with medical claims, to retain the availability of punitive damages to redress particularly acute cases of wrongdoing, the precise circumstances in which such damages would be recoverable could be defined with far greater precision, and specific ***468** monetary limitations could be placed on such awards. [FN42]

Proposing to address deficiencies in the medical malpractice system through a private, i.e., contractual, solution is prompted by a recognition that authorization through governmental action, whether in the form of legislation or regulation, will meet substantial resistance from entrenched interest groups. A legislative or regulatory resolution would, of course, be preferable. It would improve the prospect for avoiding issues as to enforceability, and even constitutionality, of contractual limitations on the right to litigate. It is, however, a reality that must be recognized that any attempt to deviate from the existing adversarial method for resolving medical malpractice claims will face intense and well-financed opposition from many attorneys. Not only the plaintiffs' negligence bar, but also the many attorneys representing insurance company defendants have a vested personal financial interest in the continuance of the existing process; and together they possess a disproportionately large influence over the political process, particularly at the state legislative level. Indeed, the state legislatures are filled with attorneys actively practicing negligence law.

Legislative or regulatory endorsement of the private arbitral approach would, of course, be desirable. Such action would serve to emphasize the consistency with overall public policy of compulsory arbitration provisions in contracts with physicians, health maintenance organizations or health insurers. Legislative (or administrative) endorsement could be as simple as a confirmation that medical malpractice claims fall within the purview of general arbitration statutes, or could be more detailed and particular and extend to such matters as the type and composition of the arbitral panel, right of appeal, and limitations on the permissible scope of damages.

The attitude of individual states to the compulsory arbitration of medical malpractice claims varies greatly. California, a leader in the development of the health maintenance organization, has for many years provided legislative and judicial support ***469** for

conditioning membership in such groups upon the participant's agreement to arbitrate. [FN43] New York, where this form of medical provider is far less common, has adopted a posture towards arbitration best described as grudging: a statute was enacted only in 1986. [FN44] This statute permitted health maintenance organizations during a limited five-year experimental period only, to allow, but not require, enrollees to elect to arbitrate malpractice claims. [FN45] Absent such enabling legislation, it would appear that arbitration could not be offered, even as a voluntary option. The New York statutory scheme [FN46] also makes clear that such arbitration may not deviate from the standards of care applicable to actions at law for medical malpractice, that damages are to be determined as in actions at law, [FN47] and that contingency fee arrangements with lawyers are permitted to the same extent as in actions at law. One useful study to be undertaken might be to compare medical malpractice "costs" in New York and California in light of the rather similar demographic characteristics of the two states and the radically differing approaches towards the malpractice claims disposition process which each has encouraged.

Governmental endorsement of the arbitral approach could also come at the federal level, either in the form of an act of Congress or through regulations of the Department of Health and Human Services. In light of the extensive federal involvement in the financing and other aspects of the provision of medical services, such as through the Medicare program, other federally-funded health insurance benefits or the financing of hospitals and clinics, the potential exists for "federalizing" the whole subject. [FN48] This could be effected through congressional action, or the issuance of regulations, mandating or endorsing the implementation ***470** through private contract of compulsory arbitration. Such action could also implement other related reforms described above, such as limitations on type or amount of allowable damages, in respect of those health care relationships in which there is sufficient degree of federal interest to confer upon Congress or the executive branch the power to make rules.

Such an approach has been proposed by the distinguished former Surgeon General, C. Everett Koop, and Senator Pete V. Domenici (R-NM), a highly respected member of the United States Senate. Contending that the Bush Administration proposals discussed above, although "sound," were insufficient, Koop and Domenici have jointly proposed "more fundamental change," calling for the removal of virtually all malpractice claims from courts and resolving them by binding arbitration. [FN49] They would require that participants in all federal health programs be required to resolve medical injury claims through binding arbitration. [FN50] The categories of persons who would be covered by this requirement would include: beneficiaries of Medicare, Medicaid and participants in Federal employees' health plans and public health and veterans programs, as well as employees of companies that obtain tax deductions for contributions to health plans. [FN51] The proponents suggest that that this would remove approximately 80 percent of all medical claims from the litigation process. [FN52]

"Federalization" would provide a means for avoiding state law disparities and for ensuring the availability of arbitration on a uniform basis throughout the nation. Moving towards such a national solution could also prove advantageous by reducing the ability of interest groups to thwart reform. "Federalization" could be implemented either through legislation or possibly, at least as to certain categories of claimants, through regulation. Congress might enact, or the Secretary of Health and Human Services might promulgate, regulations either endorsing the implementation, through private contract, of compulsory arbitration in respect of health care relationships in which there is a sufficient federal interest, or even mandating the arbitration of ***471** private claims arising out of such health care relationships. Federal intervention establishing arbitration as either a permissible or mandatory dispute-resolution procedure could, under principles of preemption, override conflicting state dispute-resolution policies permitting litigation or prohibiting or disfavoring arbitration.

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[FN1]. Robert Pear, Health-Care Costs Up Sharply Again, Posing New Threat, N.Y. TIMES, Jan. 5, 1993, at A1 [hereinafter Pear].

[FN2]. Senator Pete V. Domenici, Health Care Reform: Should curbing medical malpractice litigation be part of the solution?, 78 A.B.A.J. 42 (Aug. 1992).

[FN3]. Id.

[FN4]. Worrying About Health, ECONOMIST, June 15, 1991, at 27.

[FN5]. Id.

[FN6]. The present litigation process for handling personal injury claims generally has, of course, been subject to much criticism entirely apart from the particular problems which it may present when employed in disputes arising out of patient treatment. The characteristics of the personal injury litigation process may, however, be particularly inappropriate when the dispute involves a claim of medical malpractice on the part of a health care professional or institution. To the extent that such is the case, we may be paying a price in the dramatic overall escalation of health care costs.

[FN7]. The field of medical malpractice has been called "the forum for initial experimentation with a program pressed by the Reagan administration and others in the 1980s: reinstatement in the tort system of the true integrity of the fault principle in order to protect defendants from the unwarranted imposition of liability, along with a substantial cutback on the potential size of damages payable even by actors whose personal and legal culpability is clearly established." See AMERICAN LAW INSTITUTE REPORTER'S STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY, at 283 (1991). See also Less Litigation, More Justice, WALL ST. J., Aug. 14, 1991, at A8, summarizing the recommendations of the Final Report of the President's Council on Competitiveness, entitled "Agenda for Civil Justice Reform in America." The premise that rampant medial malpractice suits are significantly contributing to problems in the operation of the civil justice system has been seriously challenged by a recent study completed by the National Center for State Courts. See Study Challenges Some Public Perceptions About Wrongful-Act Suits WALL ST. J., Oct. 8, 1992, at B10.

[FN8]. Philip J. Hilts, Bush Enters Malpractice Debate With Plan to Limit Court Awards, N.Y. TIMES, May 13, 1991, at A1 [hereinafter Hilts]. The presumed relationship between malpractice and escalating health care costs is widely assumed; a fifth grader, writing in a student publication of this author's son's elementary school, lamented the plight of those unable to afford health care, concluding that "if doctors didn't have to pay all the malpractice bills they do, they wouldn't have to charge so much." To this writer's surprise, the student's parents were not even physicians!

[FN9]. Id.

[FN10]. Id.

[FN11]. Pete V. Domenici and C. Everett Koop, Sue the Doctors? There's A Better Way, N.Y. TIMES, June 6, 1991, at A25 [hereinafter Domenici and Koop]. This article cites an 18% annual increase in medical liability premiums from 1982 through 1988. There is, however, evidence that this trend has levelled off. See AMERICAN LAW INSTITUTE REPORTER'S STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY, at 3 (1991), noting that in the three-year period ending 1986, medical malpractice premiums rose from $2 billion to more than $5 billion. By comparison, in 1991 the total was only $5.6 billion.

[FN12]. AMERICAN LAW INSTITUTE REPORTER'S STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY, at 285 (1991).

[FN13]. Hilts, supra note 8, at A1.

[FN14]. AMERICAN LAW INSTITUTE REPORTER'S STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY, at 287 (1991) (noting that such premiums represented almost 5% of amounts paid for physician services in 1988).

[FN15]. Id.

[FN16]. Id. at 288.

[FN17]. Domenici and Koop, supra note 11.

[FN18]. Hilts, supra note 8, at A1.

[FN19]. See Pear, supra note 1; see also James B. Couch, Employers' Role in Improving Medical Care Value, 14 SETON HALL LEGIS. J. 65 (1990).

[FN20]. Barry Manuel, M.D., Alternative Forms of Dispute Resolution, 75 AM. COLL. OF SURGEONS BULL. 9 (Dec. 1990)[hereinafter Manuel].

[FN21]. A. Russell Localio, et al., Relation Between Malpractice Claims and Adverse Events Due to Negligence, 325 NEW ENG. J. MED. 245 (July 25, 1991) (emphasis added).

[FN22]. Id.

[FN23]. Id.

[FN24]. In responding to the Bush Administration proposals, Paul C. Weiler, of Harvard Law School, contended, "[T]here is a problem, but it is a somewhat different problem than the administration thinks it is. There are many doctors who are sued when they should not be. The awards from juries can be far too high and are always unpredictable. But there is another side of the problem: There are far more people being hurt by doctors, and even hurt by negligence, than the number who actually file suit. We need to compensate them, too." Hilts, supra note 8, at A1.

[FN25]. Theodore Eisenberg and Kevin Clermont, Trial by Jury or Judge: Transcending Empiricism, 77 CORNELL L.REV. 1124 (July 1992).

[FN26]. Id. at 1137.

[FN27]. Randall R. Bovbjerg, Medical Malpractice: Folklore, Facts and the Future, 117 ANNALS OF INTERNAL MEDICINE 788 (Nov. 1, 1992).

[FN28]. Id. (emphasis added).

[FN29]. Michael J. Saks, Do We Really Know Anything About the Behavior of the Tort Litigation System--And Why Not?, 140 U.PA.L.REV. 1147 (1992). The author notes that "[h]ealth care costs have risen at a faster rate and to greater heights than the overall cost of living." Id.

[FN30]. This expresses the author's own opinion.

[FN31]. This discussion does not attempt to take into account other considerations which might militate in favor of reform. It has been argued that fear of medical malpractice claims has resulted in significant physician dissatisfaction and has contributed to a decrease in the number of persons entering the field of medicine. See Taragin, et al., The Influence of Standard of Care on the Resolution of Medical Malpractice Claims, 117 ANNALS OF INTERNAL MEDICINE 780 (Nov. 1, 1992); see also Manuel, supra note 20. It does not, of course, follow from this that merely changing the modality of dispute resolution--from litigation to arbitration--would necessarily, or in and of itself, correct physician dissatisfaction.

[FN32]. See, e.g., CAL.CIV.PROC.CODE § 1295 (West 1992); ARIZ.REV.STATE ANN. § 12-1501 (1993); MD.CTS. & JUD.PROC.CODE ANN. § 3-2A-01 (1992)

[FN33]. Bank of America, the nation's largest banking institution, has recently undertaken a program requiring its credit card customers and depositors to submit all disputes to binding arbitration. Ralph T. King, Jr., Banks Force Griping Customers to Forego Courts For Arbitration, WALL ST. J., Jan. 20, 1993, at B1. Notably, Consumer Action, a nonprofit organization, and the California Trial Lawyers Association immediately brought suit to cancel the policy change. The bank's approach represents an extension of the bank's previous policy of requiring arbitration in its commercial lending relationships. Employers are also now regularly utilizing agreements obligating their employees to arbitrate disputes, including claims relating to sexual harrassment and racial discrimination. Wade Lambert, Employee Pacts to Arbitrate Sought by Firms, WALL ST. J., Oct. 22, 1992, at B1.

[FN34]. 9 U.S.C. § 1 (1988).

[FN35]. Id.

[FN36]. Summit Health, Ltd. v. Pinhas, 111 S.Ct. 1842 (1991).

[FN37]. See Edward Felsenthal, Antitrust Suits Are on the Rise in Health Field, WALL ST. J., Oct. 26, 1992, at B1.

[FN38]. Disputes arising in tort, such as claims for personal injury, are arbitrable and there is case law in some states specifically sanctioning the enforcement of agreements to arbitrate medical malpractice claims, including agreements entered into as a condition to participation in health insurance plans. Such contracts have been upheld on the grounds that they do not take away rights but merely prescribe a particular remedial forum, and in the face of the contention that they are contracts of adhesion entered into between parties of vastly unequal bargaining power, and thus should not be enforced. There is also case law which indicates that such agreements may be made binding upon a patient's heirs, successors and assigns, so that a malpractice action involving a claim for wrongful death would also be subject to compulsory arbitration.

[FN39]. Garrity v. Lyle Stuart, Inc., 353 N.E.2d 793 (N.Y.1976).

[FN40]. Id. at 794.

[FN41]. Id. at 797.

[FN42]. Punitive damages have also been seen as sometimes necessary to encourage legitimate claimants to come forward where their identifiable economic losses are slight in relationship to the costs of prosecuting their claims; by employing an arbitration process which should be much less expensive, this concern will be alleviated and the rationale for allowing such damages substantially eroded.

[FN43]. See supra note 32.

[FN44]. N.Y. PUB. HEALTH LAW § 4406-a (McKinney 1993).

[FN45]. Id.

[FN46]. See N.Y. CIV. PRAC. L. & R. § 7552 (McKinney 1993); N.Y. INS. LAW § 5605 (McKinney 1993); N.Y. PUB. HEALTH LAW § 4406-a (McKinney 1993).

[FN47]. Query whether this means that, contrary to New York's general policy on punitive damages, arbitrators in such actions may award punitive damages?

[FN48]. Governments, federal and state, presently pay 42% of health care costs and lavishly subsidize private insurance using tax credits. See Robert J. Samuelson, Nationalize Health Care, NEWSWEEK, Oct. 26, 1992, at 20. The federal share of Medicaid in 1992 was $67.8 billion and federal spending for Medicare was $129.4 billion. See CONGRESSIONAL BUDGET OFFICE REPORT, THE ECONOMIC AND BUDGET OUTLOOK: FISCAL YEARS 1994-1998, at 132 (Jan. 26, 1993).

[FN49]. Domenici and Koop, supra, note 11.

[FN50]. Id.

[FN51]. Id.

[FN52]. Id.
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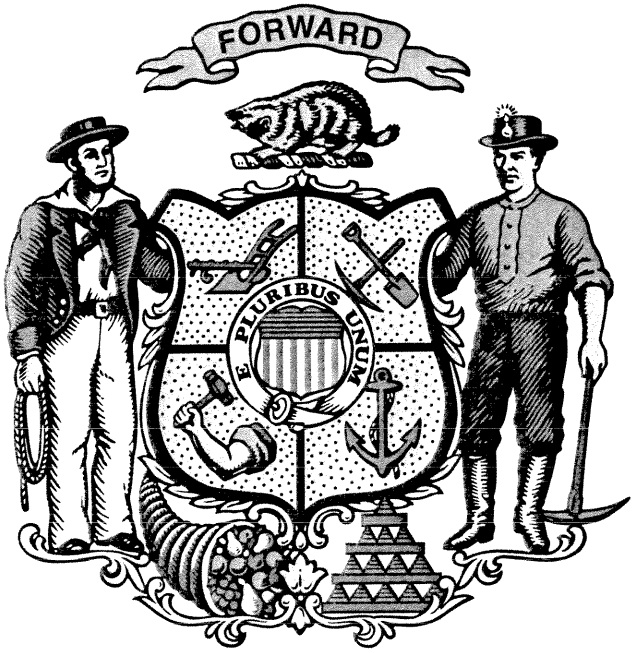
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Notes and Comments

*115 MANDATORY MEDICAL MALPRACTICE SCREENING PANELS: A NEED TO REEVALUATE

Dennis J. Rasor

I. INTRODUCTION

The cost of health care in the United States is a serious problem facing government. National health care expenditures have captured a higher percentage of the Gross National Product (GNP) every year since the mid-1960s. [FN1] Total U.S. health care expenditures in 1991 accounted for thirteen percent of the GNP [FN2] -- the highest percentage of gross national product spent on health care by any nation. [FN3] State government health care expenditures in the United States average over fourteen percent of each state's budget. [FN4]

Not surprisingly, the cost of obtaining health insurance has also increased dramatically. [FN5] The growing number of uninsured Americans is a devastating consequence of the rising cost of medical care that society must face. In 1987, 15.5% of all Americans were without medical insurance. [FN6] Most of the uninsureds were working Americans. [FN7] The number of uninsureds rose to 34.7 million in 1990, the highest number since 1965. [FN8] The increases in health insurance costs are substantially impacting the middle class. Families earning over $25,000 per year accounted for over seventy-five percent of the increase in uninsured Americans in 1990, [FN9] and families earning over $50,000 per year accounted for over thirty-three percent of the increase. [FN10]

*116 The facts indicate a serious problem that lawmakers must address. The concern over the rising cost of medical care is not new, and analysts have offered many reasons for the increase. [FN11] Some blame the high cost of medical malpractice insurance. [FN12] During his campaign, President Clinton cited the high cost of physician malpractice insurance as one conspirator in the health care problem. The President called for implementing alternative dispute resolution techniques nationwide as a means of reducing the cost of medical malpractice insurance. [FN13]

In response to skyrocketing medical malpractice insurance premiums during the 1970s and 1980s, many states enacted tort reform to address this perceived crisis. Some of these reforms included: removing ad dannum clauses (plaintiff's demand for damages), permitting voluntary arbitration, regulating attorney's fees, abolishing the collateral source rule (rule prohibiting evidence of plaintiff's recovery for injuries from a party other than the defendant), increasing penalties for frivolous suits, creating patient compensation funds (variations on a no-fault system), and establishing pretrial screening panels. [FN14] This Comment focuses on pretrial screening panels when specifically mandated as a precondition to traditional litigation in medical malpractice cases.

Pretrial medical malpractice screening panels ("screening panels") have been classified as both arbitration and mediation. Some screening panels are similar to arbitration because they result in formal decisions by a third party as to the legal rights and responsibilities of the parties. However, screening panels more closely resemble mediation because they are not absolutely binding: They do not necessarily replace traditional litigation. Nevertheless, mediation may also be a misnomer. [FN15] Mediation is a proceeding that encourages voluntary settlement. Screening panels do more. They make qualitative assessments about liability, thereby acting as a "screen" by separating valid claims from frivolous *117 ones. Screening panels also often make quantitative assessments about liability; [FN16] however, they vary from state to state. The most salient features of the different mandatory screening panels are the composition of the panels and the admissibility of panel findings at a subsequent trial. [FN17]

The overriding legislative purpose behind mandatory screening panels is to reduce the cost of health care. [FN18] This Comment considers the desirability of mandatory screening panels as a means of curbing the increasing cost of health care. Part I of this Comment questions the connection between mandatory screening panels and reduced medical care costs by (1) analyzing how the cost of medical malpractice insurance has affected the cost of medical care and (2) analyzing how mandatory screening panels have affected the cost of medical malpractice insurance. Part II discusses the constitutionality of mandatory screening panels under state constitutional theories of (1) right to trial by jury, (2) due process, and (3) equal protection. The issues that underlie the constitutional analysis are also relevant to the question of the desirability of mandatory screening panels. Part III discusses the policy considerations for future tort reform and analyzes the problems with current mandatory screening panel procedures.

II. THE CONNECTION BETWEEN THE COST OF MEDICAL CARE AND MANDATORY SCREENING PANELS

A. The Cost of Medical Malpractice Insurance and the Cost of Medical Care

Ultimately, the use of mandatory screening panels as a worthy means of tort reform depends greatly upon the extent that it can help promote access to health care by making it more affordable. [FN19] In order ***118** to accomplish this goal, the cost of medical malpractice insurance must have a significant impact on the cost of health care.

The high and increasing cost of medical malpractice insurance has been blamed as a main contributor to the high cost of both medical care and health insurance for the past two decades. [FN20] Medical malpractice insurance premiums increased dramatically from 1974 to 1985. [FN21] For example, the cost of medical malpractice insurance rose from 3.1% of physicians' gross income in 1982 to 4.6% in 1985. [FN22] However, this increase peaked in 1987 at 5.6% and fell to 4.8% by 1989. [FN23] In 1990, premiums showed declines of five percent to thirty-five percent nationwide. [FN24] Premiums continued to decline slightly in 1991. [FN25] The cost of malpractice insurance was reduced even for obstetricians and neurosurgeons in 1988 and 1989. [FN26] St. Paul Fire and Marine Insurance Company, the largest insurer of liability for physicians and hospitals, reduced medical malpractice premiums during 1989- 90, and it reduced premiums in 1990 through 1991 by a rate of six percent to twenty-five percent in twenty-one of the forty-two states in which it operates. [FN27] The nation's largest insurer again announced that it would not raise malpractice premiums in 1993. [FN28] Despite the halt in increasing costs of medical malpractice premiums, physician fees are continuing to rise alarmingly. In 1990, physician fees increased fifty percent faster than the consumer price ***119** index. [FN29]

The cost of medical malpractice insurance can not be greatly responsible for the increase in the cost of medical care. During the period of increase in medical malpractice premiums, the total bill for malpractice insurance only accounted for 0.9% in 1983 and 1.22% in 1985 of the total national health care cost. [FN30] In 1989, premiums were less than one percent of the total health care cost and that fell by another four percent in 1991. [FN31] During this most recent decline in the costs of malpractice insurance, health care costs have "skyrocketed." [FN32] Recent data suggests that the cost of medical malpractice suits, as exhibited through malpractice premiums, has little effect on the total cost of health care in the United States.

On the other hand, the cost of malpractice suits may affect the cost of health care more indirectly, through what is commonly termed "defensive medicine." The actual cost of defensive medicine may never be known. [FN33] An American Medical Association survey revealed that over eight out of ten physicians practice defensive medicine. [FN34] The American Medical Association also estimated in 1985 that defensive medicine cost twelve billion dollars; [FN35] however, it is not clear what practices were included in their definition of defensive medicine.

The U.S. Department of Health, Education and Welfare, Commission on Medical Malpractice, defined "defensive medicine" as "the alteration of modes of medical practice, induced by the threat of liability, for the principal purpose of forestalling the possibility of lawsuits by patients as well as providing a good and legal defense in the event such lawsuits are instituted." [FN36] As defined, defensive medicine only includes performing procedures not medically justified or omitting medically beneficial procedures because of the fear of a later malpractice suit. [FN37] It does not include alterations in medical practices that may result from fear of a later malpractice suit but that are also medically justified. Much of ***120**

the cost of defensive medicine may be due to a perceived threat that does not exist. Physician surveys revealed that the overall perceived risk of being sued was about three times the actual risk. [FN38] Legislators should question whether these physicians' fears of unwarranted malpractice claims are legitimate before attempting to reduce the cost of defensive medicine by reducing the number of malpractice claims.

Malpractice liability is largely based upon a duty to act like a reasonable physician in like circumstances. [FN39] Legislators should first ask whether the duty imposed upon physicians is reasonable or desirable. The mandatory screening panel is an additional procedure imposed upon plaintiffs' ability to recover. Such tort reform should not be usedto lower the liability of physicians for breach of their duties to their patients.

The United States Department of Health, recognizing that the practice of defensive medicine is itself immoral, recommended that medical organizations exert maximum moral persuasion over physicians who avoid professional responsibility solely on the fear of malpractice liability. [FN40] However, the perceived "threat of litigation has changed the doctor-patient relationship into a defensive and adversarial relationship." [FN41] This alone is a serious problem facing society. Legislators must decide whether physician liability should be removed to help calm the fears of physicians or whether other methods of tort reform may reduce the cost of defensive medicine. Most importantly, any tort reforms that are enacted should attempt to bring back mutual respect to the doctor-patient relationship.

B. Mandatory Screening Panels and the Cost of Medical Malpractice Insurance

Four factors commonly cited as responsible for cost increases in medical malpractice insurance are: (1) an increase in loss payments (claims paid), (2) excessive insurance company profits, (3) attributes of the insurance industry underwriting cycle, and (4) the insurance risk *__121__ classification system. [FN42] The driving rationale behind the support for mandatory screening panels is their ability to "screen" out meritless claims, thereby helping to reduce the amount of claims paid. Mandatory screening panels are intended to resolve medical malpractice disputes more efficiently than traditional litigation, thereby saving transaction costs and ultimately the cost of loss payments. [FN43] This section will focus on the increase in loss payments because it is the one factor that mandatory screening panels are designed to impact most directly.

Assuming mandatory screening panels are able to reduce the number of medical malpractice claims, a correlation between reduced numbers of claims filed and paid, and reduced cost of malpractice insurance must exist in order for mandatory screening panels to accomplish their purpose. The number of medical malpractice claims filed and the cost of medical malpractice insurance both rose during the 1970s and 1980s. [FN44] However, the trend has reversed in recent years. The number of malpractice claims filed has been on the decline since 1985. [FN45] In 1988, the rate of increase in the cost of medical malpractice insurance premiums began to fall, and beginning in 1989 the actual cost of premiums began to fall. [FN46] Insurers have not been able to explain which combination *__122__ of social, legal, and economic factors has allowed the reductions. [FN47]

The apparent correlation between the reduced number of claims paid and the reduced cost of malpractice insurance may, however, be illusory. There was a sharp drop in the number of malpractice

claims filed in Massachusetts through mid-1992; nonetheless, the Joint Underwriting Association filed for a fourteen percent increase in premiums in Massachusetts for 1993. [FN48] Premiums for obstetricians went down while the number of claims filed against them rose. [FN49] Additionally, evidence compiled by Frank A. Sloan during the 1980s led to the conclusion that the size and frequency of claims paid are only weakly related to premium increases. [FN50] Mandatory screening panels may reduce the cost of malpractice insurance not only by reducing the number of insurance claims paid but also by reducing the transaction costs of malpractice litigation. However, the evidence from court records suggests that mandatory screening panels have had little success in resolving disputes faster and cheaper than traditional litigation. In its first four years of operation, the mandatory screening panel in Rhode Island resolved only 57 of the 266 controversies brought before it; 209 controversies remained unresolved. [FN51] The legislature of Rhode Island responded by overhauling the system, making it more akin to a formal pretrial conference. [FN52] A study of Wisconsin's mandatory screening panels found that over seventy percent of all claims ended up starting traditional litigation. [FN53] The Pennsylvania Supreme Court found their mandatory screening panel to be unconstitutional due to its inability to effectuate its legislative purpose of providing a prompt determination of claims. [FN54] During the operation of the mandatory screening panels in Pennsylvania between April 1976 and December 1979, 2,909 claims were filed with the administrator but only 134 were actually given certificates of readiness to begin screening panel proceedings. [FN55] Of these 134 cases, 14 were tried before the screening panels, 23 were settled during panel selection process, and one was continued per court order; 96 of the 134 ***123** cases had not yet been decided by the screening panels. [FN56]

Other reasons for the reduction in medical malpractice premiums have been suggested. In addition to the reversal of the insurance companies' policies of setting premiums higher than needed, [FN57] increased competition in the insurance industry has been noted as causing premium reductions. [FN58] The Vice President of the American Medical Association cited an increase in the use of physician-owned insurance companies that "generally do not work to make a profit" as a reason for the decline. [FN59] Moreover, the Massachusetts Medical Society cited heightened efforts by physicians at risk management and improved quality of care as the principal reasons for the reduced premiums. [FN60] One study found that the three tort reforms that have had the greatest impact on the cost of premiums were: (1) abolition of the collateral source rule, (2) shorter statutes of limitations, and (3) caps on damages (primarily pain and suffering). [FN61] The evidence suggests that mandatory screening panels have not been an effective method of tort reform to reduce the cost of medical malpractice insurance.

The connection between the cost of medical malpractice insurance and the cost of health care is tenuous at best. If the purpose of mandatory screening panels is to help reduce the cost of medical care by reducing the cost of medical malpractice insurance, then the rationale for mandating the use of screening panels should be re-evaluated. If screening panels are unable to dispose of claims more quickly and less expensively than traditional litigation, then their only benefit accrues to defendants who have gained the protection of another layer of time and bureaucracy. In such a situation, "[i]t cannot seriously be contended that the extension of special benefits to the medical profession and the imposition of an additional hurdle in the path of medical malpractice victims relate to the protection of the public health." [FN62]

*124 III. CONSTITUTIONALITY OF MEDICAL MALPRACTICE SCREENING PANELS

The mandatory use of pre-trial screening panels has been attacked under several state and federal constitutional theories in many jurisdictions. [FN63] The majority of courts have upheld the constitutionality of mandatory screening panels. However, some courts have found them either unwise or outright unconstitutional. [FN64] As these tort reform measures enjoy longer periods of utilization, their effectiveness in reducing the cost of medical malpractice insurance and, ultimately, the cost of health care becomes increasingly important not only for court analysis, but also for legislative analysis and public debate.

Mandatory screening panels have been challenged most often under the following state constitutional theories: (1) the right to trial by jury, (2) substantive due process, and (3) equal protection. The most common determinative factor among the three is the balancing of the burden on individual litigant's rights and the benefits to society at large. [FN65] As discussed earlier, the overriding impetus behind legislative mandating of screening panels is to control spiraling medical care costs. [FN66] The preceding section examined the possible effect screening panels may have on the cost of medical care. This section will examine some of the constitutional and policy considerations that must be balanced against the effectiveness of mandatory screening panels in dealing with the medical care "crisis."

A. Right to Trial By Jury

The mandatory use of pretrial screening panels has been attacked in many jurisdictions as an infringement upon the fundamental right to a jury trial. [FN67] The Federal Constitution has been construed not to provide a right to a jury trial in state civil claim cases. [FN68] However, many state constitutions provide an explicit right to a jury trial in both criminal and ***125** civil trials. [FN69] Mandatory screening panels have been challenged as violations of the right to a jury trial predominately under two theories: (1) Submission of the panel conclusions at the jury trial unduly impairs the ability of the jury to decide all issues of fact de novo; and (2) increased cost of submitting the case to the panel unduly burdens the litigant's right to present the case to a jury.

1. Impairment of De Novo Jury Trial

The challenge that mandatory screening panels unduly impair the ability of the jury to decide the issues of fact, in violation of the state right to a trial by jury, has been largely unsuccessful. [FN70] Clearly, in those jurisdictions where the conclusions of the panel are not admissible in the subsequent trial, [FN71] no infringement upon the jury's determination of fact exists. The Colorado Supreme Court upheld the constitutionality of their screening panel on the condition that the conclusions of the panel not be admissible in the subsequent trial, thereby guaranteeing a trial de novo. [FN72] Where admission of the panel conclusions is allowed, the constitutionality of the admission has usually been upheld under the theory of legislative discretion to formulate rules of evidence. The most extreme case is Attorney General of Maryland v. Johnson. [FN73] Under Maryland's provision for mandatory screening panels, the conclusions of the panel are not only admissible but also presumed correct. The Maryland Court of Appeals upheld the presumption of correctness as a prerogative of the legislature and the courts to formulate and decide upon the admissibility of evidence. [FN74]

Jurisdictions have found the admissibility of panel conclusions to be constitutional for conflicting reasons. The Supreme Courts of Arizona and Wisconsin found that because panel members may not be

called as witnesses at the subsequent trial, any prejudicial effect upon the jury is *126 contained and therefore its admissibility does not infringe upon the right to a jury trial. [FN75] Conversely, the New Jersey Supreme Court held that either party must be allowed to cross-examine panel members at trial as to credibility and possible bias in order for the screening panels to be constitutional. [FN76] The Louisiana Supreme Court held that the ability to call any panel member as a witness at trial was essential in providing an acceptable forum for a litigant to have the facts determined by the jury de novo. [FN77] The New York Court of Appeals and the Alaska Supreme Court made similar holdings. [FN78] On the other hand, the Maryland statute does not allow panel members to be witnesses at trial; nor does it allow the jury to consider whether the panel conclusion was influenced by fraud, partiality, or the like. [FN79] The Maryland Court of Appeals held that this fact "has no relevance whatever to whether the parties receive that to which they are entitled -- a de novo jury trial of the malpractice claim." [FN80] In Maryland, the inability to challenge the panel members' credibility on the witness stand removes the attribute that the New Jersey, Louisiana, and New York courts found necessary -- cross-examining the panel members at trial. Moreover, the presumption in Maryland is that the panel's conclusions are correct. This presumption removes the very attribute of avoiding the undue influence on the jury's de novo review that Arizona's and Wisconsin's rules against panel member testimony seek to insure. For these reasons, the Maryland system is unique. These contradictory holdings weaken the persuasiveness of treating the admission of mandatory screening panels' conclusions as simply rules concerning "expert" testimony.

*127 2. Undue Burden

Challenging mandatory screening panels under the theory that the increased costs incurred therein are an unreasonable burden upon the right to a jury trial has had limited success. [FN81] The Supreme Court of Pennsylvania held that the increased cost and delay of screening panels were unjustified burdens upon litigants in medical malpractice cases and, therefore, violated the right to a jury trial under the Pennsylvania Constitution. [FN82] The Pennsylvania court found the mandatory use of screening panels unconstitutional only two years after finding the same provision constitutional. [FN83] In the first case, Parker v. Children's Hospital of Philadelphia, the court held that the Pennsylvania Constitution "does not require an absolutely unfettered right to a jury trial." [FN84] Most courts have interpreted the analogous language of other state constitutions to contain similar limitations. [FN85] The Pennsylvania court held in Parker that arbitration as a condition precedent to trial was not a per se violation of the right to a jury trial. [FN86] Two years later, however, the court in Mattos v. Thompson held that during the interim the panels had proven unable to effectuate the legislative purpose of swift adjudication of claims at a minimal cost. [FN87] The court found that because the statute mandating screening panels no longer reasonably effectuated the compelling state interest, it violated the constitutional right to a jury trial. [FN88] Other courts have also seriously questioned the effectiveness of screening panels to control the cost of malpractice insurance and health care. [FN89] However, most courts have declined to seriously consider the legislative wisdom in *128 mandating screening panels under the right to jury theory. [FN90]

B. Substantive Due Process

Due process clauses in state constitutions often include specific "access to courts" provisions for civil suits. [FN91] Mandatory screening panels have been attacked as unduly prohibiting access to the courts

in violation of state due process clauses. In no state has mandatory, binding screening panels, or other arbitration proceedings been a prerequisite to a court hearing in a medical malpractice suit. It is the postponement of the right to access to the courts that screening panels create that becomes the focus of constitutional analysis. [FN92] As is the case with the right to trial by jury, the added expense of the screening panels has been claimed to be unduly burdensome on the right to access to the courts in violation of due process. [FN93] However, the right to access to the courts has never been without restriction. Legislatures are free to restrict access to the courts if such restriction is reasonable to effectuate a legitimate state purpose. [FN94] A balancing test must be used similar to that used in the right to jury trial theory. Most courts that have addressed this issue have utilized a low level of scrutiny. [FN95] The Missouri Supreme Court, however, interpreted the right of access to the courts to be fundamental and, by implication, used strict scrutiny to find the mandatory screening panel unconstitutional. [FN96] Most legislatures have imposed mandatory screening panels to curb the rising cost of malpractice insurance. [FN97] If screening panels are rationally related to this purpose, then, under low-level scrutiny, they will not violate a plaintiff's right to access to the courts.

In addition to challenges under "access to courts" provisions, mandatory screening panels have also been attacked as violations of due process on the theory that they change the common law right of redress ***129** for medical negligence. Courts have consistently rejected this theory. [FN98] As the Indiana Supreme Court noted in Johnson v. St. Vincent Hospital, "[t]he relationship of health care provider and patient imposes . . . a common law legal duty. The nature and extent of that duty may be modified by legislation. Hence, the Legislature may also validly act to restrict the remedy available for breach of that duty." [FN99] Based on the resistance of courts to adopt this theory in the past, it appears unlikely that mandatory screening panels will be found unconstitutional under this theory of due process at any time in the near future.

C. Equal Protection

The balancing test used in right to trial by jury and due process theories is similar to the low level scrutiny test used in equal protection analysis. Attacks on mandatory screening panels have commonly arisen under equal protection analysis. [FN100] Legislatures have singled out medical malpractice suits for mandatory screening panels. This differential treatment from other torts is subject to equal protection analysis. The appropriate level of scrutiny is a question of law that varies from state to state. [FN101] Most states utilize low-level scrutiny to analyze the impact of mandatory screening panels. [FN102]

Low-level scrutiny may be generalized as requiring legislation to be reasonably related to a legitimate state interest. [FN103] This is a two-part analysis. First, the state interest that the legislation is attempting to protect (the "end") must be legitimate. Second, the method that the legislature has employed to effectuate that purpose (the "means") must be reasonable. Therefore, mandatory screening panels in medical malpractice cases must be rationally related to reducing the cost of health care (assuming that reducing the cost of health care is a legitimate state interest). States using low-level scrutiny have consistently upheld the constitutionality of mandatory screening panels under equal protection analysis. [FN104] Rhode Island and Wyoming, however, have found ***130** mandatory screening panels to be unconstitutional using low-level equal protection analysis. [FN105]

In Maryland, where the most radical form of mandatory screening panels is used, the Maryland Court

of Appeals employed a higher level of scrutiny but upheld the constitutionality of mandatory screening panels for medical malpractice torts. [FN106] A higher level of scrutiny is used when either a suspect classification or a fundamental right is adversely affected. [FN107] Screening panels will be analyzed under a higher level of scrutiny if either the medical malpractice plaintiff or the medical malpractice defendant constitutes a "suspect class." Most courts have been unwilling to categorize the classification of medical malpractice plaintiffs or defendants as "suspect." [FN108] However, Louisiana did find that medical malpractice litigants were a suspect class: "Because the Act 'constitutes a special legislation provision in derogation of general rights available to tort victims' it must be strictly construed." [FN109]

Screening panels will also be analyzed under a higher level of scrutiny if they negatively affect a fundamental right. The right to access to the courts and the right to a jury trial have been found to be such fundamental rights. [FN110] States such as Missouri, where screening panels have been found to violate the fundamental right to access to the courts, and Illinois, where screening panels were found to violate the fundamental right to a jury trial, would probably have utilized strict scrutiny under equal protection analysis had such analysis been necessary.

The interrelationship between the right to jury trial, due process, and equal protection is important when analyzing mandatory screening panels. Equal protection analysis depends greatly upon the determination of whether the right to jury trial or an aspect of due process ("access to courts") is a fundamental right. In addition, the right to jury trial and due process often utilize the same analysis as that used under equal protection.

In all three areas of constitutional analysis, the issue of deference to the legislature is often the underlying consideration. The higher the level of scrutiny used by the court, the lower the amount of deference afforded the legislative determination. The final determination as to ***131** constitutionality will depend upon the deference given to the legislatures' determinations that a heath care crisis exists and that screening panels will help solve this crisis.

Recently, in Hoem v. State, the Wyoming Supreme Court declined to give the legislature the sweeping deference often given by courts who considered mandatory screening panels in the past. [FN111] The court criticized giving legislatures too much deference:

> Most state courts give considerable deference to the state legislatures' specific declarations in statutes that such a crisis does exist and that the substantive portions of the statute are intended to alleviate that crisis. A better approach for those courts that have yet to decide the issue would be, however, to take a more skeptical attitude toward the evidence presented by the medical profession and the insurance industry and toward the conclusion reached by the state legislature regarding the existence of a crisis . . . Proper scrutiny of the constitutional validity of state legislation demands more than a perfunctory deferral to the legislature's conclusions regarding the existence of a health care crisis in the particular state. [FN112]

Because the evidence suggests that: (1) the cost of medical malpractice premiums has declined; [FN113] (2) the size and frequency of medical malpractice claims have little effect on the cost of malpractice insurance; [FN114] and (3) the cost of medical malpractice insurance contributes only slightly to the cost of health care, [FN115] the Wyoming Supreme Court's approach is persuasive. The courts are the final protectors of individual plaintiffs' and defendants' rights. Courts should not shrink from their duty

to protect the minority behind a vague notion of deference to legislatures, especially in an area of traditional judicial cognizance, namely the right of injured individuals to seek redress in the courts.

*132 IV. POLICY CONSIDERATIONS AND RECOMMENDATIONS

Courts have found mandatory screening panels to be constitutional, to be unconstitutional, and to reach "the outer limits of constitutional tolerance." [FN116] A battleground for abandonment or implementation of mandatory screening panels also exists in the state legislatures. [FN117] If Congress enters the arena of tort reform, as indicated by a recent bill introduced by Senator Orrin Hatch (R-UT), then this battle will certainly intensify. [FN118] Moreover, the President has indicated that tort reform will be a priority in his health care reform package. [FN119] The United States Department of Health and Human Services published a list of policy objectives for tort reform in the area of medical malpractice. [FN120] The following were the top three objectives: (1) to assure the availability of health care, (2) to increase the quality of care, and (3) to enhance the physician-patient relationship.

As the cost of health care increases, the availability decreases. Part II of this Comment analyzed the effectiveness of mandatory screening panels in reducing the cost of health care. The evidence suggests that mandatory screening panels have little effect on the cost of health care. Moreover, despite the cost of medical malpractice insurance, physician entry into the market has not been barred. The ratio of physicians per 100,000 individuals in the United States increased from 211 in 1980 to 252 in 1987, [FN121] a time period which experienced increases in malpractice insurance premiums. [FN122] Consequently, it is unlikely that malpractice premiums significantly deter the entry of new physicians, especially in light of the recent premium reductions.

The primary purpose of the tort system is to provide compensation to individuals who have been wrongly injured according to society's standards. Assuring the availability of health care is not the province of the tort system. The focus of tort reform should concentrate more heavily on: (1) providing fair and prompt compensation to injured patients, (2) improving the quality of care, and (3) enhancing the physician-patient relationship.

*133 A. Providing Fair and Prompt Compensation to Injured Patients

Studies show that our current system provides compensation only to a small proportion of those patients injured as a result of medical malpractice. [FN123] The purpose of the screening panel should shift from "screening" out what it considers frivolous or meritless claims to facilitating the voluntary settlement of disputes. The function of determining the facts of the underlying claim should be left to traditional litigation.

Formal panel conclusions on liability that are admissible at trial tread upon the functions of the judge and jury. The judge and jury are the fundamental components of our judicial system. When the state operates to judge the relationship between private citizens through the judicial system, our society has determined that finding the truth is the ultimate responsibility of a fact finder in court. To ensure the finding of truth, our system has developed as an adversarial one. Presumably, that is why current screening panels are more adversarial than traditional voluntary, nonbinding mediation. However, the fair operation of an adversarial procedure necessitates the use of the Rules of Evidence. Many of the

current mandatory screening panels do not operate under these rules. For example, Michigan's screening panel is not required to follow the Rules of Evidence. Moreover, neither party is permitted to be heard by the panel in making its determination of liability. [FN124]

While the conclusions of the screening panels are not absolutely binding upon the parties, they do significantly affect the parties' interests. Many states require the party that petitions a trial court from a screening panel decision to post a bond to the court. This bond is then used to pay the costs of the opposing party if the panel award is not substantially modified at trial. Moreover, many states allow the panel conclusions to be admitted at trial as "expert testimony" but do not allow cross-examinations of the panel members at trial. [FN125] This removes the long established principle of cross-examination essential to the confrontation clause.

The Rules of Evidence and other "formalities" of traditional litigation are present to ensure the finding of the truth. Mandatory screening panels operate as finders of fact without the safeguards developed over hundreds of years of experience in our American legal ***134** system. For this reason, the current functions of mandatory screening panels operate to deprive parties to medical malpractice cases of the right to a fair and honest resolution of their claims and, therefore, are illegitimate.

Unfortunately, our traditional system has failed to provide a reliable avenue for reimbursement of injuries for negligence, reducing the deterrent effect of monetary damages. In the State of New York in 1984, eight times as many patients had an injury from malpractice as filed claims, and sixteen times as many patients suffered injury from negligence as received compensation. [FN126] Screening panels and similar nonbinding arbitration may be good methods for making the system of compensation more accessible to patients with legitimate malpractice claims. However, evidence like that found by the Pennsylvania Supreme Court in Mattos v. Thompson, [FN127] where screening panels only delayed resolution of claims and added to their expense, suggests that screening panels may not be the best answer.

A radical solution to this problem is setting up a no-fault compensation system much like workers compensation systems. This has the advantage of a quid pro quo. Plaintiffs sacrifice the opportunity for full compensation for intangibles like pain and suffering while physicians must pay for injuries not resulting from negligence or willful conduct. One major advantage of this system would be that plaintiffs would not have to wait long to receive compensation. Likewise, physicians would not have to be tied up in protracted legal battles, presumably freeing their consciences from anger at the patients. The physician-patient relationship would likely benefit.

One negative side effect of a no-fault system is the removal of the tort system from the quality control network. In order for the no-fault system to be attractive, other institutions like physician peer groups and government agencies would have to increase controls over quality care. In addition, implementation of a no-fault compensation system in medical injury cases would have to pass equal protection analysis. The disparate treatment of medical injury in this instance from other torts is apparent. Implementing a no-fault system requires a revolution in American thinking. Americans feel that a person who negligently injures another should have to pay all resulting damages, including those like "pain and suffering." This is at the heart of American common law torts. As a result, nationwide no-fault medical injury systems may not be forthcoming.

*135 B. Improving the Quality of Care

A committee of the Association of the Bar of New York City, which was well-represented by hospital and insurance professionals as well as defense advocates, recently studied the existence of the "insurance crisis" and concluded that "improving the quality of health, not further restricting the ability of injured plaintiff's to sue," is where New York should place its primary focus. [FN128] The quality of health care in the U.S. has been less than optimal. In 1990, infant mortality rates were higher per capita in the United States than in Belgium, France, England, West Germany, and Sweden. [FN129] The rate of death in the United States from infectious and parasitic diseases in 1990 was twice that of Belgium, Sweden, and West Germany, and three times as much as England. [FN130]

The tort system has traditionally been a source of help in the improvement of the quality of health care in the United States. William F. Minogue, Medical Director at the George Washington University Medical Center, said, "[malpractice litigation] has produced the very case law that has been such a powerful and legitimate motivator for change in hospitals." [FN131] The tort system should continue to be one method of spotting negligent physicians. The Editor of the New England Journal of Medicine estimated that in 1985 at least five percent of all physicians should not have been practicing medicine. [FN132] It is estimated that one percent of all physicians are negligent each year. [FN133] State medical boards, however, take action against about only 0.5% of the nation's physicians each year. [FN134] Moreover, most of this action is not taken for negligent practice but for drug abuse and the sale of illegal drugs. [FN135] The threat of liability continues to be a motivator for quality control. The Journal of the American Medical Association found that physician-owned insurance companies, which are financially motivated to prevent medical negligence, were weeding out negligent physicians faster than state medical *136 boards. [FN136] Tort reform that simply creates barriers to bringing valid negligence suits frustrates the needed deterrent value our tort system should provide.

C. Enhancing the Physician-Patient Relationship

"Threat of litigation has changed the doctor-patient relationship into a defensive and adversarial relationship." [FN137] Before the enactment of any tort reforms, legislators should consider the effect upon the physician-patient relationship. Traditional litigation is formal and adversarial. It has created hostility and fear between physicians and patients. However, the screening panel is also an adversarial process. The adversarial nature of claim resolution translates into a defensive and adversarial relationship between physician and patient. [FN138]

The screening panel procedure can be modified to help protect the physician-patient relationship by ensuring confidentiality. Admitting the record and conclusions of the screening panel at a subsequent trial forces the panel proceedings to be more adversarial. Physicians are legitimately concerned about the effect malpractice claims have upon the reputation of their practices. The overreaction of physicians practicing defensive medicine may largely be explained by the aversion physicians have to having a public claim for negligence reach the courthouse. Settlement in a structured proceeding is much more likely to occur if physicians are free from fear of the retaliation, increased insurance cost, and investigation [FN139] attendant to public proceedings. Moreover, since a de novo trial is constitutionally required, admission of the panel conclusion has little value. The parties are still likely to

use key expert witnesses at trial. The value of admitting the conclusions of the screening panel is outweighed by the burden it places on settlement between parties who could then leave the process without resentment.

D. Future Use of the Screening Panel

Despite the major shortcomings of the mandatory screening panel, some useful notions can be salvaged. The active participation of neutral experts in a structured mediation is an asset that should be maintained by the state. Furthermore, participation in such a process greatly facilitates *137 discovery of relevant information [FN140] that is useful in settlement negotiations. Most importantly, such a mediation process should garner respect from both the medical profession and the public. Such respect can only be earned, however, by providing a system that is both fair and efficient. Effective alternative dispute resolution can only be achieved if the parties to the proceeding have confidence in the fairness of the system.

Because experience has shown that the only fair way for the state to impose a solution on the parties is through the formal fact-finding procedure of traditional litigation, any mandatory mediation should be nonbinding and have no effect on the rights of unwilling parties. The mandatory mediation should facilitate voluntary settlement through a conciliatory atmosphere. To avoid igniting already adverse interests, proceedings should be confidential. Trust from the parties that the alternative dispute resolution is fair is essential.

A good mediation panel would be chaired by a professional mediator who would have control over the proceedings. Professional mediators are useful in keeping the proceedings amicable. Promoting settlement between hostile interests is no easy task. The worse the parties' relationship, the dimmer the chance mediation will be successful. [FN141] Why shouldn't professionals be utilized to tackle such an obstacle?

Each side should be allowed to participate equally in the choice of the qualified experts who will serve on the mediation panel. Many states do not afford the parties any choice in the mandatory screening panel membership. [FN142] In addition, no legal professionals are needed on the mediation panel. Each party should be represented by legal counsel. Additional legal professionals on the panel only intensify the impression that a formal legal judgment is being rendered. If this is not the case, why are judges and lawyers needed on the panel? The most important feature of the mediation panel should be its purpose in facilitating an amicable, fair solution to the parties' dispute in a more cost efficient manner. If this is not accomplished, parties should be free to move on to traditional litigation without any prejudice from their attempt to reach an earlier settlement.

*138 V. CONCLUSION

Although the cost of health care is certainly a major problem facing America, it does not appear that the cost of medical malpractice insurance is a significant factor. Moreover, the mandatory screening panel has not been able to prove itself successful in reducing the cost of medical malpractice insurance. This connection is essential to the effectiveness of mandatory screening panels in resolving the "health care crisis." Mandatory screening panels deny parties long established individual rights reaching, if not

exceeding, the limits of constitutional protection. These individual rights should not be sacrificed in the name of the public health without certainty that they are necessary. States should re-evaluate their mandatory screening panels and modify their purpose from "weeding out" unwanted medical malpractice claims to facilitating amicable, efficient settlement of claims whenever possible. The goals of promoting quality health care, promoting the physician-patient relationship, and protecting the rights of injured patients should be incorporated into any mandatory alternative dispute resolution technique. The goal of mandating a resolution of disputes between parties should be left to our traditional judicial system where our adversary system has developed to protect the integrity of the fact-finding process.

[FN1]. Frank A. Sloan et al., Finding Solutions to Problems of Access, Quality Assurance, and Cost Containment, in COST, QUALITY, AND HEALTH CARE 1, 2 (Frank A. Sloan et al. eds., 1988).

[FN2]. Walter A. Costello, Jr., President Message, MASS. LAW WKLY, June 8, 1992, at 37.

[FN3]. STEVEN E. PENGALIS & HARVEY F. WACHSMAN, AMERICAN LAW OF MEDICAL MALPRACTICE 2d § 2:9 at 56 (1992).

[FN4]. Michael Tanner, As Washington Dithers, States Reform Health Care, HERITAGE FOUND. REP., Nov. 27, 1991, at Sec. Backgrounder, No. 868.

[FN5]. For a general discussion, see MARY FRANCES CALLEN & DAVID CLARK YEAGER, CONTAINING THE HEALTH CARE COST SPIRAL (James Bessent, ed. 1991). See also Judith Graham, Health Care Crisis: Spiraling Costs Anger Employers in Colorado, U.S., DENVER POST, Oct. 1990, at C1.

[FN6]. ROBERT P. RHODES, HEALTH CARE POLITICS, POLICY AND DISTRIBUTIVE JUSTICE: THE IRONIC TRIUMPH, 254 (1992).

[FN7]. Tanner, supra note 4 (Nearly 85% of all Americans without health insurance are either employed or dependents of an employed person.).

[FN8]. Robert Pear, 34.7 Million Lack Health Insurance, Studies Say; Number Is Highest Since '65, N.Y. TIMES, Dec. 19, 1991, at B17.

[FN9]. Id.

[FN10]. Id.

[FN11]. CALLEN & YEAGER, supra note 5, at 2. Callen lists six reasons for the spiraling cost of health care: (1) new technology, (2) cost of research and development of new medicine and diagnostic tools, (3) higher cost of malpractice insurance, (4) minimizing the possibility of malpractice litigation by documentation and many tests and supporting opinions [defensive medicine], (5) services provided to uninsured and indigent, and (6) lack of decision making by patients once in medical provider system. Id.

[FN12]. Rep. Charles Stenholm & Rep. John Kyl, Joint News Conference on Health Care Costs and

Malpractice, FED. NEWS SERVICE (Oct. 8, 1991).

[FN13]. Bill Clinton, The Clinton Health Care Plan, 327 NEW ENG. J. MED. 804, 806 (1992).

[FN14]. For a discussion of these various reforms, see NANCY K. BANNON, AM. MED. ASS'N., AMA TORT REFORM COMPENDIUM (1989).

[FN15]. Catherine S. Meschievitz, Mediation and Medical Malpractice: Problems with Definition and Implementation, 54 LAW & CONTEMP. PROBS. 195, 198 (Winter 1991).

[FN16]. BANNON, supra note 14, at 113.

[FN17]. See infra Chart A, at app.

[FN18]. See Stephen Zuckerman, Information on Malpractice: A Review of Empirical Research on Major Policy Issues, 49 LAW & CONTEMP. PROBS. 85 (Spring 1986).

[FN19]. The United States Department of Health and Human Services listed eight policy objectives for tort reform: (1) availability of health care; (2) quality of health care; (3) enhancement of physician-patient relationship; (4) encourage innovation for improved level of health care; (5) fault as a basis for compensation; (6) prompt resolution and fair compensation; (7) predictability [of outcomes]; and (8) efficient financial costs, professional energies, and governmental processes [transaction costs]. U.S. DEPT. OF HEALTH AND HUMAN SERV., REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE at 17-19 (Aug. 1987).

[FN20]. Stenholm & Kyl, supra note 12.

[FN21]. Randall R. Bovbjerg, Legislation on Medical Malpractice: Further Developments and Preliminary Report Card, 22 U.C. DAVIS L. REV. 499, 505 (1988- 89).

[FN22]. U.S. DEPT. OF HEALTH AND HUMAN SERV., supra note 19, at 13.

[FN23]. Martin L. Gonzalez, Medical Professional Liability Claims and Premiums, 1985-1991, in SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE 36 (American Medical Association, Center for Health Policy Research, Chicago, 1993).

[FN24]. Robert Pear, Insurers Reducing Malpractice Fees for Doctors in U.S., N.Y. TIMES, Sept. 23, 1990, at A1. The reductions have varied among states. For example, in 1990 rates were reduced in Maine by 32%, in Kansas by 25%, in Georgia by 23%, in Minnesota by 15%, in Colorado by 10% and in Pennsylvania by 6.7% and again by another 15%. Id. In California, rates declined 37.8% from 1976-1991 when adjusted for inflation. Ruth Gastel, Medical Malpractice, INS. INFO. INST. REP., Oct. 1992, available in LEXIS, Nexis Library, Current File.

[FN25]. See Gastel, supra note 24.

[FN26]. U.S. DEPT. OF HEALTH AND HUMAN SERV., supra note 19, at 166.

[FN27]. Malpractice Liability in the United States: Panic Over?, 301 BRIT. MED. J. 949, 949-50 (1990).

[FN28]. See Ruth Gastel, Medical Malpractice, INS. INFO. INST. REP., Aug. 1993, available in LEXIS, Nexis Library, Current File. However, insurers in New York were granted a fourteen percent average increase effective July 30, 1993; the first increase in four years. Id.

[FN29]. Pear, supra note 24, at A26.

[FN30]. U.S. DEPT. OF HEALTH AND HUMAN SERV., supra note 19, at 175.

[FN31]. Costello, supra note 2, at 37.

[FN32]. Id.

[FN33]. PENGALIS & WACHSMAN, supra note 3, at 50.

[FN34]. See Gastel, supra note 24.

[FN35]. Issues Related to Medical Malpractice: Hearing Before the Subcommittee on Health, Committee on Ways and Means, 101st Cong. 2d Sess. 49 (1990).

[FN36]. PENGALIS & WACHSMAN, supra note 3, at 49.

[FN37]. Id.

[FN38]. HARVARD MEDICAL MALPRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 9 (1990).

[FN39]. See, e.g., Greenberg v. Perkins, 845 P.2d 530 (Colo. 1993).

[FN40]. PENGALIS & WACHSMAN, supra note 3, at 51.

[FN41]. Tom Cameron, LI Health Care: Where Do We Begin?, LI BUS. NEWS, May 16, 1991, at 5H.

[FN42]. David J. Nye et al., The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances, 76 GEO. L.J. 1495, 1511 (1988). Much has been written blaming either the insurance industry or the increases in malpractice insurance premiums. See Issues Related to Medical Malpractice, supra note 35, at 26. This Comment is not intended to conclude this debate. Some authority exists for assuming that excessive insurance profits have contributed to the cost of medical malpractice. See PENGALIS & WACHSMAN, supra note 3, at 53 (study by the Commissioner of Minnesota Department of Commerce finding that between 1982-87 insurers charged rates which were

considerably more than necessary to cover losses and expenses and also realize a healthy profit); Costello, supra note 2, at 37; Pear, supra note 24, at A1. Assuming both excessive insurance profits and increasing claim costs had some effect on increasing premiums through the 1980s, this Comment's scope is limited to addressing the extent claim frequency, severity, and subsequent tort reforms have affected medical malpractice premiums.

[FN43]. See, e.g., Prendergast v. Nelson, 256 N.W.2d 657, 662 (Neb. 1977).

[FN44]. Bovbjerg, supra note 21, at 505-06.

[FN45]. Malpractice Liability in the United States: Panic Over?, supra note 27, at 949. Figures released in 1990 by St. Paul Fire and Marine Insurance Company, the largest insurer of liability for physicians and hospitals, showed that the number of claims filed dropped every year from 1985 through 1990. Issues Related to Medical Malpractice, supra note 35, at 166; see also Gastel, supra note 28. While the number of claims has fallen nationwide, individual states may see increases in 1993; for example, New York experienced a slight increase in 1992-93. Moreover, the rate of claims filed varies drastically between specialties; for example, the rate of claims filed against obstetricians and gynecologists has increased by seventy-one percent over the past five years. Gastel, supra note 28.

[FN46]. See supra notes 23-28 and accompanying text.

[FN47]. Malpractice Liability in the United States: Panic Over?, supra note 27, at 950.

[FN48]. See Gastel, supra note 24.

[FN49]. Gastel, supra note 28.

[FN50]. Frank A. Sloan, Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment, 9 J. OF HEALTH, POL., POL'Y. & L. 629, 643 (1985).

[FN51]. Boucher v. Sayeed, 459 A.2d 87, 89 (R.I. 1983).

[FN52]. Id. at 89-90.

[FN53]. Meschievitz, supra note 15, at 211.

[FN54]. Mattos v. Thompson, 421 A.2d 190, 193-94 (Pa. 1980).

[FN55]. Id. at 194.

[FN56]. Id.

[FN57]. See PENGALIS & WACHSMAN, supra note 3, at 53; Pear, supra note 24, at A1.

[FN58]. Pear, supra note 24, at A1.

[FN59]. Id.

[FN60]. See Gastel, supra note 24.

[FN61]. Issues Related to Medical Malpractice, supra note 35, at 17. Note the absence of mandatory screening panels. Compare Sloan, supra note 50, at 640 (The existence of both mandatory and voluntary screening panels show a negative impact on cost of premiums.).

[FN62]. Hoem v. State, 756 P.2d 780, 783 (Wyo. 1988).

[FN63]. See infra Chart B, at app.

[FN64]. See infra Chart B, at app.

[FN65]. See, e.g., Usery v. Turner Elkhorn Mining Co., 428 U.S. 1 (1976); Mattos v. Thompson, 421 A.2d 190 (Pa. 1980).

[FN66]. Stenholm & Kyl, supra note 12; Eastin v. Broomfield, 570 P.2d 744, 751 (Ariz. 1977); Carter v. Sparkman, 335 So. 2d 802, 806 (Fla. 1976); Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585, 589-94 (Ind. 1980); Attorney Gen. v. Johnson, 385 A.2d 57, 71 (Md. 1978); State ex rel. Strykowski v. Wilkie, 261 N.W.2d 434, 442 (Wis. 1978).

[FN67]. See infra Chart B, at app.

[FN68]. Minneapolis & St. Louis R.R. v. Bombolis, 241 U.S. 211, 217 (1916).

[FN69]. See, e.g., Wright v. Central Du Page Hosp. Ass'n., 347 N.E.2d 736, 740 (Ill. 1976) (In Illinois, the constitution provides, "the right of trial by jury as heretofore enjoyed shall remain inviolate." Ill. Const., art. I, § 13).

[FN70]. The most popular case finding mandatory screening panels unconstitutional under this theory is Simon v. St. Elizabeth Medical Center, 355 N.E.2d 903 (Ohio C.P. 1976). However, this case has not been persuasive. See, e.g., Attorney Gen. v. Johnson, 385 A.2d 57, 67 (Md. 1978).

[FN71]. See infra Chart A, at app.

[FN72]. See Firelock, Inc. v. McGhee Comm., Inc., 776 P.2d 1090 (Colo. 1989).

[FN73]. 385 A.2d 57 (Md. 1978).

[FN74]. Id. at 79.

[FN75]. Eastin v. Broomfield, 570 P.2d 744, 749 (Ariz. 1977); State ex rel. Strykowski v. Wilkie, 261 N.W.2d 434, 450 (Wis. 1978).

[FN76]. Perna v. Pirozzi, 457 A.2d 431, 436 (N.J. 1983).

[FN77]. Everett v. Goldman, 359 So. 2d 1256, 1264 (La. 1978); see also Galloway v. Baton Rouge Gen. Hosp., 602 So. 2d 1003, 1006 (La. 1992).

[FN78]. Comiskey v. Arlen, 390 N.Y.S.2d 122, 124 (1976); Keyes v. Humana Hosp. Alaska, Inc., 750 P.2d 343, 355 (Alaska 1988); Treyball v. Clark, 483 N.E.2d 1136, 1137 (N.Y. 1985).

[FN79]. Md. Cts. & Jud. Proc. Code Ann., § 3-2A-06(c),(e) (1992); see also Attorney Gen. v. Johnson, 385 A.2d 57, 67 (Md. 1978).

[FN80]. Attorney Gen. v. Johnson, 385 A.2d 57, 70 (Md. 1978).

[FN81]. See Mattos v. Thompson, 421 A.2d 190 (Pa. 1980); see also Simon v. St. Elizabeth Medical Ctr., 355 N.E.2d 903 (Ohio C.P. 1976).

[FN82]. Mattos, 421 A.2d at 196.

[FN83]. Parker v. Children's Hosp., 394 A.2d 932, 938 (Pa. 1978).

[FN84]. Id.

[FN85]. See, e.g., State ex rel. Strykowski v. Wilkie, 261 N.W.2d 434, 449 (Wis. 1978).

[FN86]. Parker, 394 A.2d at 938.

[FN87]. Mattos, 421 A.2d at 195.

[FN88]. Id. at 193. (Note that the Court found the screening panels unable to help the medical care crisis. The cost of malpractice insurance was still continuing to rise at this time, and therefore, the state's interest in reducing the cost was presumably still compelling.).

[FN89]. See Boucher v. Sayeed, 459 A.2d 87 (R.I. 1983); see also Hoem v. State, 756 P.2d 780 (Wyo. 1988).

[FN90]. Beatty v. Akron City Hosp., 424 N.E.2d 586, 590 (Ohio 1981); see also infra Chart B, at app.

[FN91]. See, e.g., Ind. Const. of 1851, art. I, § 12 (amended 1984).

[FN92]. See, e.g., Mattos v. Thompson, 421 A.2d 190, 193 (Pa. 1980).

[FN93]. See, e.g., Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585, 593 (Ind. 1980).

[FN94]. Id. at 594; see also State ex rel. Strykowski v. Wilkie, 261 N.W.2d 434, 444 (Wis. 1978).

[FN95]. Arneson v. Olson, 270 N.W.2d 125, 132 (N.D. 1978); Linder v. Smith, 629 P.2d 1187, 1191 (Mont. 1981).

[FN96]. State ex rel. Cardinal Glennon Memorial Hosp. for Children v. Gaertner, 583 S.W.2d 107, 110 (Mo. 1979).

[FN97]. See Zuckerman, supra note 18.

[FN98]. Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585, 594 (Ind. 1980); Prendergrast v. Nelson, 256 N.W.2d 657, 663-64 (Neb. 1977).

[FN99]. St. Vincent Hosp., 404 N.E.2d at 594.

[FN100]. See infra Chart B, at app.

[FN101]. An excellent overview of the traditional levels of scrutiny used in equal protection analysis can be found in Boucher v. Sayeed, 459 A.2d 87, 91 (R.I. 1983).

[FN102]. See, e.g., Beatty v. Akron City Hosp., 424 N.E.2d 586, 591-92 (Ohio 1981).

[FN103]. West Coast Hotel Co. v. Parish, 300 U.S. 379, 391 (1927).

[FN104]. Beatty, 424 N.E.2d at 594.

[FN105]. Boucher, 459 A.2d at 93; Hoem v. State, 756 P.2d 780, 782 (Wyo. 1988).

[FN106]. Attorney Gen. v. Johnson, 385 A.2d 57, 77-78 (Md. 1978) (statute passing intermediate standard of "means-focused" test requires substantial relation).

[FN107]. Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585, 597 (Ind. 1980).

[FN108]. See, e.g., State v. Senno, 398 A.2d 873, 878 (N.J. 1979).

[FN109]. Galloway v. Baton Rouge Gen. Hosp., 602 So. 2d 1003, 1005 (La. 1992) (quoting Head v. Erath Gen. Hosp., 458 So. 2d 579, 581-82 (La. Ct. App. 1984).

[FN110]. State ex rel. Cardinal Glennon Memorial Hosp. for Children v. Gaertner, 583 S.W.2d 107, 110 (Mo. 1979).

[FN111]. Hoem v. State, 756 P.2d 780, 784 (Wyo. 1988).

[FN112]. Id. (quoting Comment, Constitutional Challenges to Medical Malpractice Review Boards, 46 TENN. L. REV. 607, 645 (1978)).

[FN113]. See supra notes 23-28 and accompanying text.

[FN114]. See Sloan, supra note 50, at 643; see also supra notes 48-50 and accompanying text.

[FN115]. See supra part II(A).

[FN116]. Carter v. Sparkman, 335 So. 2d 802, 806 (Fla. 1976).

[FN117]. The Vermont Legislature recently changed their screening panel from a voluntary one to a mandatory one. Vt. Stat. Ann., tit. 12, § 46 (1992).

[FN118]. Stenholm & Kyl, supra note 12.

[FN119]. Clinton, supra note 13 at 806.

[FN120]. U.S. DEPT. OF HEALTH AND HUMAN SERV., supra note 19, at 166.

[FN121]. RHODES, supra note 6, at 217.

[FN122]. See supra notes 21-22 and accompanying text.

[FN123]. Issues Related to Medical Malpractice, supra note 35, at 9 (statement of Charles A. Bowsher, Comptroller General of the United States).

[FN124]. Mich. Comp. Laws § 600.4913, ch. 49 (1992).

[FN125]. See infra Chart A, at app.

[FN126]. HARVARD MEDICAL MALPRACTICE STUDY, supra note 38, at 6.

[FN127]. Mattos v. Thompson, 421 A.2d 190, 196 (Pa. 1980).

[FN128]. PENGALIS & WACHSMAN, supra note 3, at 54 (quoting The Record of the Association of the City of New York, Vol. 45, No. 5, at 573 (June 1990)).

[FN129]. TIMOTHY S. JOST, ASSURING THE QUALITY OF MEDICAL MALPRACTICE: AN INTERNATIONAL COMPARATIVE STUDY 70 (1990).

[FN130]. Id.

[FN131]. PENGALIS & WACHSMAN, supra note 3, at 56.

[FN132]. See Gastel, supra note 24.

[FN133]. HARVARD MEDICAL MALPRACTICE STUDY, supra note 38, at 3; see also Issues

Related to Medical Malpractice, supra note 35, at 8.

[FN134]. Issues Related to Medical Malpractice, supra note 35, at 6.

[FN135]. Id.

[FN136]. See Gastel, supra note 24.

[FN137]. Cameron, supra note 41, at 5H.

[FN138]. Id.

[FN139]. Meschievitz, supra note 15, at 200-01.

[FN140]. Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585, 592 (Ind. 1980).

[FN141]. Rhonda G. Parker, Mediation: A Social Exchange Framework, MEDIATION Q., Fall 1991-92, at 121-133.

[FN142]. See infra Chart A, at app.

*139 APPENDIX

Chart A

States' Mandatory Medical Malpractice Screening Panels

State	Salient Features of Screening Panels						
	Panel Membership				Panel Conclusion Admissible	Panel Testimony Admissible	Panel Select. By Party [FN1]
	HCP [FNa1]	Atty	Judge	L/P [FNaa1]			
AL [FN2]	3/3				YES	YES	NO
AR [FN3]	1/3	1/3	1/3		YES	NO	NO
CO [FN4]				3/3P	NO	NO	YES

DE [FN5]	2/5	1/5		2/5L	YES	- [FN6]	YES [FN7]
FL [FN8]					YES	NO	NO
GA [FN9]				3/3P	NO	NO	NO
HI [FN10]	1/3	1/3		1/3P	NO	NO	NO
ID [FN11]	2/4	1/4		1/4L	NO	NO	NO
IL [FN12]	1/3	1/3	1/3		NO	- [FN13]	YES
IN [FN14]	3/4	1/4			YES	YES	YES
LA [FN15]	3/4	1/4			YES	YES	NO
ME [FN16]	1/3	1/3	1/3 [FN17]		YES	NO	NO
MD [FN18]	1/3	1/3		1/3L	YES	NO	YES
MA [FN19]	1/3	1/3	1/3		NO [FN20]	- [FN21]	NO
MI [FN22]	2/5	3/5			NO	NO	YES
MO [FN23]	2/6	2/6	1/6		NO	NO	NO
MT [FN24]	3/6	3/6			NO	NO	NO
NE [FN25]	3/4	1/4			YES	YES	YES
NV [FN26]	3/6	3/6			YES	NO	NO
NJ [FN27]	1/3	1/3	1/3		YES	YES	NO

					[FN28]	[FN29]
NM [FN30]	3/6	3/6			NO	NO	NO
NY [FN31]	1/3	1/3	1/3		YES [FN32]	YES	NO
ND [FN33]	2/5	2/5		1/5 [FN34]	YES	YES	YES
OH [FN35]		3/3			YES	YES	YES
PA [FN36]	1/3	1/3		1/3L	YES [FN37]	- [FN38]	NO
RI [FN39]	1/3	1/3		1/3P	YES [FN40]	- [FN41]	NO
TN [FN42]	1/3	1/3		1/3L	YES	NO	NO
VT [FN43]	1/3		1/3	1/3L	YES	YES	NO
VA [FN44]	2/5	2/5	1/5		YES	YES	NO
WI [FN45]	2/5	1/5		2/5L	YES	NO	NO
WY [FN46]	2/5	2/5		1/5L	NO	NO	NO

FNa1. HCP = Health Care Professional;
FNaa1. L = Layman, P = Professional Mediator
FN1. This column refers to the screening panel membership selection process. States have many variations on panel selection. This chart notes affirmative party participation only where parties are equally free to make choices from a substantial list of qualified individuals or where parties are given unlimited or substantial peremptory challenges.

FN2. ALASKA STAT. § 09.55.536 (1976).
FN3. ARIZ. REV. STAT. ANN. § 12-567 (1976) (repealed 1989).
FN4. COLO. REV. STAT. § § 13-22-401 to -409 (1987) (Pilot district only).
FN5. DEL. CODE ANN. tit. 18, § § 6802-6821 (1976).
FN6. This issue is not addressed in the statute. See, e.g., DEL. CODE ANN. tit. 18, § 6812 (1989 & Supp. 1992).

FN7. Only if parties unanimously agree. DEL. CODE ANN. tit. 18, § 6805(2) (1989 & Supp. 1992).

FN8. FLA. STAT. ANN. § 768.44 (West 1975) (repealed 1983).
FN9. Fulton Super. Ct. Local R. 1000, repealed by Uniform Rules for the Superior Courts, 1.1 (1985).

FN10. HAW. REV. STAT. § § 671-11 to -20 (1976 & Supp. 1992).
FN11. IOWA CODE § § 6-1001 to -1011 (1976).
FN12. ILL. REV. STAT. ch. 110, para. 2-1012 to -1020 (1985) (repealed 1990).
FN13. This issue is not addressed in the statute. See, e.g., ILL. REV. STAT. ch. 110, para. 2-1018(d) (1985) (repealed 1990).

FN14. IND. CODE § 16-9.5-9-1 to -10-5 (1975).
FN15. LA. REV. STAT. ANN. § 40:1299.47 (West 1975) (amended 1991).
FN16. ME. REV. STAT. ANN. tit. 24, § § 2851-2859 (West 1992).
FN17. Retired judges only. ME. REV. STAT. ANN. tit. 24, § 2852 (West 1992).
FN18. MD. CTS. & JUD. PROC. CODE ANN. § § 3-2A-03 to -09 (1976).
FN19. MASS. GEN. L. ch. 231, § 60B (1988).
FN20. The Massachusetts statute reads, 'The testimony of said witness and the decision of the tribunal shall be admissible as evidence at trial.' Id.

However, the Massachusetts Supreme Court held that 'decision' as used in the statute referred to the tribunals decision to appoint an impartial expert witness. The determination of the tribunal was held to be inadmissible. Beeter v. Downey, 442 N.E.2d 19 (1982). This interpretation of the statute was driven by the Court's belief: 'were such 'evidence' to be admitted and insulated from further comment from either the trial judge or opposing counsel, however, the likelihood of unfair prejudice flowing from this result might well reach constitutional limits.' Id. at 22. The Court rejected the argument that the legislature intended to make such evidence admissible as an exception to the hearsay rule. Id.

FN21. This issue is not addressed in the statute. MASS. GEN. L. ch. 231, § 60B (1988).

FN22. MICH. COMP. LAWS ANN. § § 600.4901 to .4923 (West 1987).
FN23. MO. REV. STAT. § 538 (Supp. 1976); see also State ex rel. Cardinal

Glennon Memorial Hosp. v. Gaertner, 583 S.W.2d 107 (Mo. 1979).

FN24. MONT. CODE ANN. § § 27-6-101 to -704 (1977).
FN25. NEB. REV. STAT. § 44-2840(2) (1976).
FN26. NEV. REV. STAT. § § 41A.003 to .097 (Supp. 1991).
FN27. N.J. Civ. R. 4:21 (amended 1983) (deleted 1989); see also Marsello v. Barnett, 236 A.2d 869 (N.J. 1967); Dubler v. Stetser, 430 A.2d 962 (N.J. Super. Ct. App. Div. 1981) (admissibility of panel findings).

FN28. Only if unanimous. N.J. Civ. R. 4:21-5 (amended 1983) (deleted 1989).
FN29. See also Carbo v. Crutchlow, 429 A.2d 547 (N.J. 1981) (stressing the importance of having the ability to cross examine physician panelist at subsequent trial).

FN30. N.M. STAT. ANN. § § 41-5-1 to -28 (Michie 1982).
FN31. N.Y. JUD. LAW § 148-a (McKinney 1974) (repealed 1991).
FN32. Admissible only if panel is unanimous. Id.
FN33. N.D. CENT. CODE § 32-29.1 (Supp. 1991); 1977 N.D. Laws 305, repealed by 1981 N.D. Laws 358.

FN34. The layperson member of the panel must represent health care consumers. 1977 N.D. Laws 305.

FN35. OHIO REV. CODE ANN. § 2711.21 (Baldwin 1987).
FN36. PA. STAT. ANN. tit. 40 § § 1301.308 to .604 (1975).
FN37. Only the panel conclusion as to liability is admissible at trial. The panel conclusion as to damages is not admissible. PA. STAT. ANN. tit. 40, § 1301.510(1975).

FN38. This issue is not addressed in the statute. Id.
FN39. R.I. GEN. LAWS § § 10-19-1 to -7 (1981), repealed by 1985 R.I. Pub. Laws 150. The Rhode Island procedure was unique. The screening panel's authority derived from the justice of the Superior Court. The justice had original jurisdiction over all medical malpractice claims and had discretion to appoint a screening panel. The panel reported its findings directly to the justice for review. 'If upon such review the court determines that the findings of the panel that the plaintiff's case is an unfortunate medical result is supported by the evidence adduced before the panel, the court shall dismiss the action with prejudice but not otherwise.' R.I. GEN. LAWS § 10-19-6 (1981). The case only proceeds to trial if a legitimate question of liability exists. Id.

FN40. Panel conclusion is only used by trial judge to determine whether to

dismiss case, similar to a summary judgment proceeding. Id.

FN41. This issue is not addressed in the statute. R.I. GEN. LAWS § 10-19-6 (1981).

FN42. TENN. CODE ANN. § 29-26-101 (1975) (repealed 1985).
FN43. VT. STAT. ANN. tit. 12, § § 7001-7009 (Supp. 1992).
FN44. VA. CODE ANN. § § 8.01-581.1 to -581.12 (Michie 1984 & Supp. 1993).
FN45. WIS. STAT. § § 655.001 to .018 (1986).
FN46. WYO. STAT. § § 9-2-1501 to -1512 (1986).

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State Supreme Courts' Constitutional Review of Medical Malpractice Screening Panel

State	Constitutional Theory [Y = Unconstitutional N = Constitutional] [(-) indicates that the court has not addressed this issue]			
	Trial By Jury	Due Process	Equal Protection	Other
Alaska [FN1]	N	N	N	N
Arizona [FN2]	N	_	N	N
Colorado [FN3]	N	N	N	N
Delaware [FN4]	N	N	N	N
Florida [FN5]	N	Y	N	_
Georgia [FN6]	N	N	N	N
Hawaii [FN7]	_	N	_	_
Idaho [FN8]	_	N	N	_

Illinois [FN9]	Y	_	_	Y
Indiana [FN10]	N	N	N	N
Louisiana [FN11]	_	N	N	_
Maryland [FN12]	N	N	N	N
Massachusetts [FN13]	N	N	N	N
Michigan [FN14]	_	_	_	_
Missouri [FN15]	_	Y	_	_
Montana [FN16]	N	N	N	N
Nebraska [FN17]	N	N	N	_
New Jersey [FN18]	N	N	N	_
New Mexico [FN19]	N	N	N	N
New York [FN20]	N	N	_	_
North Dakota [FN21]	_	_	_	_
Ohio [FN22]	N	_	N	_
Pennsylvania [FN23]	Y	_	_	_
Rhode Island [FN24]	_	_	Y	_
Tennessee [FN25]	_	_	_	_
Virginia [FN26]	N	_	_	_

Wisconsin [FN27]	N	N	N	N
Wyoming [FN28]	_	_	Y	_

FN1. Keyes v. Humana Hosp. Alaska Inc., 750 P.2d 343 (Alaska 1988).
FN2. Eastin v. Broomfield, 570 P.2d 744 (Ariz. 1977).
FN3. Firelock, Inc. v. McGhee Comm., Inc., 776 P.2d 1090 (Colo. 1989).
FN4. Lacy v. Green, 428 A.2d 1171 (Del. 1981).
FN5. Carter v. Sparkman, 335 So. 2d 802 (Fla. 1976) (holding statute in general to be constitutional under right to trial by jury, due process and equal protection); Aldana v. Holub, 381 So. 2d 231 (Fla. 1980) (holding application of mandatory medical malpractice screening panel operated to deny due process of law).

FN6. Davis v. Gaona, 396 S.E.2d 218 (Ga. 1990).
FN7. Tobosa v. Owens, 741 P.2d 1280 (Haw. 1987).
FN8. Hawley v. Green, 788 P.2d 1321 (Idaho 1990); Jones v. State Bd. of Medicine, 555 P.2d 399 (Idaho 1976).

FN9. Wright v. Central DuPage Hosp. Ass'n. 347 N.E.2d 736 (Ill. 1976). After Wright, the legislature modified its mandatory screening panel in order to conform to the Illinois Constitution as applied in Wright. However, the Illinois Supreme Court revisited the constitutional issues under the new act and held it violated the Illinois Constitution under the separation of powers doctrine. Bernier v. Burris, 497 N.E.2d 763 (Ill. 1986).

FN10. Johnson v. St. Vincent Hosp., Inc., 404 N.E.2d 585 (Ind. 1980).
FN11. Everett v. Goldman, 359 So. 2d 1256 (La. 1978).
FN12. Attorney Gen. of Maryland v. Johnson, 385 A.2d 57 (Md. 1978).
FN13. Paro v. Longwood Hosp., 369 N.E.2d 985 (Mass. 1977); see also Kopycinski v. Aserkoff, 573 N.E.2d 961 (Mass. 1991).

FN14. There has been no constitutional review by Michigan's courts of Michigan's current mandatory screening panel per se. However, the courts have been divided on the constitutionality of the bond requirement. Compare, Dunn v. Emergency Physicians Medical Group, 437 N.W.2d 762 (Mich. Ct. App. 1991); and Knoke v. Michlin Chem. Corp., 470 N.W.2d 420 (Mich. Ct. App. 1991).

FN15. State ex rel. Cardinal Glennon Memorial Hosp. v. Gaertner, 583 S.W.2d 107 (Mo. 1979).

FN16. Linder v. Smith, 629 P.2d 1187 (Mont. 1981).
FN17. Prendergast v. Nelson, 256 N.W.2d 657 (Neb. 1977).
FN18. Perna v. Pirozzi, 457 A.2d 431 (N.J. 1983).
FN19. Otero v. Zouhar, 697 P.2d 493 (N.M. Ct. App. 1984); rev'd on other grounds, Otero v. Zouhar, 697 P.2d 482 (N.M. 1985).

FN20. In re Colten v. Riccobono, 496 N.E.2d 670 (N.Y. 1986) (due process); Treyball v. Clark, 483 N.E.2d 1136 (N.Y. 1985) (due process and trial by jury).

FN21. North Dakota trial courts have held the screening panel act unconstitutional but the North Dakota Supreme Court reversed all these decisions because of a lack of jurisdiction or because the issues were not properly raised before the court. Ness v. St. Aloisius Hosp., 301 N.W.2d 647 (N.D. 1981); Boedecker v. St. Alexius Hosp., 298 N.W.2d 372 (N.D. 1980); Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978).

FN22. Beatty v. Akron City Hosp., 424 N.E.2d 586 (Ohio 1981).
FN23. Mattos v. Thompson, 421 A.2d 190 (Pa. 1980).
FN24. Boucher v. Sayeed, 459 A.2d 87 (R.I. 1983) (hinting that the statute also violated the state constitutional right to a jury trial).

FN25. For a discussion of state court review of Tennessee's first mandatory screening panel procedure, see Robert L. Lockaby, Jr., Comment, Constitutional Challenges to Medical Malpractice Review Boards, 46 TENN. L. REV. 607, 632 (1978-79). The constitutionality of Tennessee's final version of the Medical Malpractice Review Board and Claim Act was not reviewed before its repeal in 1985.

FN26. Speet v. Bacaj, 377 S.E.2d 397 (Va. 1989).
FN27. State ex rel. Strykowski v. Wilkie, 261 N.W.2d 434 (Wis. 1978).
FN28. Hoem v. State, 756 P.2d 780 (Wyo. 1988).

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