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Medical review panel report

Many states have tried using medical review panels to reduce the number of medical malpractice cases adjudicated. Few states still use them; more states are leaning toward mandatory arbitration or mediation systems operated by the courts. Medical courts are proposed as another alternative for diverting the flow of malpractice cases out of the civil litigation system.

Hawaii, Idaho, Indiana, Maine, Maryland, Michigan, Montana, Nebraska, New Mexico, Utah and Wisconsin are using voluntary or mandatory medical review panels. Most of those states report no data is being kept regarding the number of review panel hearings, the outcomes or any impact the process is having on medical malpractice liability insurance premiums.

History

According to the American College of Surgeons, medical malpractice screening panels date from the 1960s, when increasing numbers of malpractice actions began filling court dockets. The concept of a screening system came from physician organizations that were convinced many cases had no legal merit. Trying these cases wasted time for both medical and legal professions and indirectly increased the cost of medical care, they believed. Rather than going directly to court, with the attendant expenditure of time and money, physicians advocated for a screening system that could evaluate complaints and discourage non-meritorious cases from going to trial. By 1996, 25 of 50 states were using screening panels in some form. However, as of 1997, no panel design had been proposed that would prevent either the plaintiff or the defendant from subsequently going to court.[1]

The ACS Professional Liability Program made a strong case in 1997 for adoption of mandatory medical review panels. The ACS alleged then that only three of the states where panels were reviewing malpractice claims before trial and making non-binding recommendations to parties to make an effort to induce settlements were considered crisis states by the American Medical Association. But of the 12 states that had repealed mandatory medical review panels legislatively

[1] American College of Surgeons Professional Liability Program, "A 20-Year Experience with Malpractice Screening Panels," by William Kridelbaugh, MD, FACS, Albuquerque, N.M. (a former regent and a current member of the ACS Board of Regents' Committee on Professional Liability), and Donald J. Palmisano, MD, JD, FACS, Metairie, La. (President of Intrepid Resources, a Medical Risk Manager Co., and a current member of the ACS Board of Regents' Committee on Liability), Bulletin of American College of Surgeons, Volume 82, No. 5, May 1997

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or judiciously, eight were listed as crisis states. And in New Mexico and Louisiana, the primary goal of medical review panels had been achieved: Many cases without merit were not pursued to court.[2]

Ordinarily, medical screening panels are a system used at or near the outset of the litigation, Michigan State University Risk and Insurance Director Patricia Fowler says. A panel is made up either partly or entirely of physicians and reviews submissions and possibly presentations by both the plaintiff and the defendant, and determines the merit of the claim. In some systems, the panel determines liability only; in other systems the panel determines both liability and damages. The determination is not binding but it is, in many systems, admissible at any subsequent trial. A panel thus can serve several functions: to identify potentially weak claims early in the litigation; to encourage settlement of valid claims; and also, in cases that do not settle and proceed to trial, to provide a neutral source of expertise that can help to inform the jury's view of the case at trial.

Thirty-one states have adopted panels, but in many states the panel systems were either repealed by the legislature or overturned by courts.[3]

Evaluation

The Utah Legislature's research team reported in 1993 that there was no objective way to determine whether the pre-litigation process there was a success. A study of five years of medical malpractice claims in Utah showed that panel rulings were an accurate prediction of 67% of the eventual outcome of the case. That suggested panel rulings provide some useful information, but participants should not decide whether to pursue their claim in court based solely on the recommendation of the panel. Sixty percent of the cases reviewed by the panels entered the legal system regardless of the panels' advice. About 40% of claims reviewed by the panels were dropped after the hearings. Another 15% were settled without entering the legal system. In addition, the hearings appeared to be useful to attorneys who had little experience in medical malpractice litigation. This group dropped a larger percentage of their claims after the hearings than their more experienced colleagues.[4]

In terms of the findings on the effect on malpractice claims in general, panels appear to increase the costs of pursuing a claim to trial because they force the parties to try the claim twice, once before the panel and once at trial, Fowler says. There is some evidence that the existence of a panel system increases the probability that plaintiffs will drop their claims without payment, but the data do not tell us whether those claims were dropped because they were found to lack merit or because the cost for pursuing them had risen. However, there is also some evidence that panels are associated with a greater rate of malpractice claiming, so there is a possibility that the existence of a panel system might encourage plaintiffs to bring claims that they might not otherwise have brought. The evidence does not suggest any systematic effect of panels on the size of the claims that end up being paid, and the evidence concerning effects on malpractice premiums is inconclusive. One study found that there was a decrease in premium levels, but it used quite early data. Another study that used data from a longer time period found no statistically significant effect on premiums for either general practitioners or general surgeons although it did find a statistically significant reduction in premiums for OB/GYNS. There is, then, the possibility that panels may, at least for OB/GYNS, produce a reduction in premiums, Fowler says. But that does not necessarily answer the question of whether panels provide a benefit overall. If they produced a reduction in premiums by discouraging the assertion of valid claims, for example, that would undermine the argument that panels were a good option for improving the system.[5]

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[2] American College of Surgeons Professional Liability Program, "A 20-Year Experience with Malpractice Screening Panels"
[3] Michigan's Opportunities and Challenges, MSU's Perspectives, Patricia J. Fowler, Director, Risk Management and Insurance, Michigan State University, 372 Administration Building, East Lansing, MI 48824-1046, http://www.msue.msu.edu/msue/iac/transition/papers/MedLiab.pdf
[4] Utah Legislative Service Report, July 1993, http://www.le.state.ut.us/audit/93_07dig.pdf
[5] Michigan's Opportunities and Challenges, MSU's Perspectives, Patricia J. Fowler

Legal challenges

The Georgia Public Policy Foundation reported in 2003 that its research showed plaintiffs have challenged mandatory medical review panels on state and federal constitutional grounds. The most common challenges were based on 1) procedural and substantive due process; 2) equal protection; 3) the right to a trial by jury; 4) the right of access to the court; and 5) separation of powers.[6]

By and large, courts dismiss challenges based on substantive due process and equal protection. Most state courts have held that medical malpractice insurance costs provided a rational basis from which the legislatures could enact mandatory medical review panels. Most courts apply the rational basis test because litigation is not a fundamental right and medical malpractice plaintiffs do not constitute a protected class. However, in Florida the mandatory medical review panel was found unconstitutional because of the legislatively drawn time period applied to waiting periods for malpractice claims.[7]

Only Wyoming struck a mandatory medical review panel provision as violating equal protection under its state constitution. The court found the link between medical panels and public health to be wanting: "We cannot condone the legislature's use of the law to protect one class of people from financial difficulties while it dilutes the rights under the constitution of another class of people. Moreover, the court determined that medical malpractice litigation served the public by enhancing the quality of care."[8]

Most courts have not viewed mandatory medical review panels as an unconstitutional burden on plaintiffs' right to a jury trial. The Alaska Supreme Court indicated that submitting a panel's conclusion to the jury was a superior option because it permitted the jury to decide the merits of that conclusion. But the Pennsylvania Supreme Court used statistical studies that examined how the mandatory medical review panel system worked for two previous years. Citing delays of one to four years between the filing and completion of the arbitration period, the court concluded that the grant of original jurisdiction to a mandatory medical review panel violated the state constitutional guarantee of a right to a jury trial.[9]

Most courts reason that juries and not panels make final decisions about medical malpractice cases. The discovery process can be ongoing during the arbitration phase, and any delays were not sufficiently long to deny access to the courts. In 1979, the Missouri Supreme Court invalidated the state's mandatory medical review panel system, saying mandatory arbitration caused a delay that violated the plaintiff's right to seek immediate redress in the courts. In Arizona, a bond requirement was struck down on the basis that indigent access to courts could not be denied.[10]

The Illinois Supreme Court is the only one that declared its mandatory medical review panel program to be a violation of the separation of powers doctrine. Mandatory medical review panel were made up of circuit judges, practicing attorneys and healthcare professionals. The parties could agree at the outset to make the panel's conclusion binding. The court held that the system was unconstitutional because the circuit court judges had to share their judicial power with non-judicial members. For example, if a judge disagreed with the attorney and physician panel members, the judge's opinion must still give way.[11]

Structural recommendations and conclusions

The Georgia Public Policy Foundation research of mandatory medical review panels resulted in the recommendation that panels should have five members and include three physicians. At least one physician should be from the same specialty

[6] Rogers Wade, President and CEO, Georgia Public Policy Foundation, 6100 Lake Forrest Drive Suite 110, Atlanta, GA 30328, (404) 256-4050
[7] Georgia Public Policy Foundation
[8] Georgia Public Policy Foundation
[9] Georgia Public Policy Foundation
[10] Georgia Public Policy Foundation
[11] Georgia Public Policy Foundation

as the defending doctor. Being available for service should be a condition to obtaining and renewing a state medical license. The panel should also include two randomly selected attorneys with some trial experience. Each side should be afforded one opportunity to strike a selected attorney. Panel members should be entitled to the same immunity as those involved in arbitration panels. Panel members should not be compensated for the first day of service. After that first day, panel members could be compensated reasonable fees. Panels should review only written evidence, such as the medical chart, affidavits and depositions. The limited review would focus the panel's inquiry on objective evidence, thereby minimizing the evaluation of witness credibility and other subjective criteria. Additionally, a focus on written evidence would reduce the amount of time a panel would need to make a recommendation. Louisiana enacted a similar system.[12]

The mandatory medical review panel needs to include some means of ensuring that parties do not view the mandatory medical review panel as a mere pretrial formality. Parties that demand a trial after the mandatory medical review panel's decision should be required to take on some risk for rejecting a panel's conclusion. Litigants should be required to wait 30 days after the finding in order to mediate and confer on the panel's finding. Many states permit the panel's conclusion to be admissible at a subsequent trial. Admissibility provides for several safeguards, including the introduction of any dissent or concurring opinion, questioning of the report before the jury, and calling panel members to testify before the jury.[13]

Michigan State University's Patricia Fowler says that providers with expertise in the technical complexities of health care delivery can streamline fact-finding and increase accuracy in decision-making. Incentives are necessary for patients and providers to accept decisions of the panel. Both approaches avoid the long delays, great expense and trauma of litigation. Money otherwise spent in the litigation process could be recycled to the benefit of all involved.[14]

But Catherine T. Struve, author of Expertise in Medical Malpractice Litigation, says one other issue is whether panel findings on liability and damages also can be a source of neutral information that the jury could use in cases that go to trial. Panels do not seem well designed to serve that role. The prospect that the panel findings could be put in front of the jury if the case does go to trial will provide an incentive for the parties to engage in longer and costlier panel proceedings. Thus, the goal of using panel findings to provide expertise to the jury at trial conflicts with the goal of using panels to provide a quicker mechanism for resolving claims earlier in the litigation process. This conflict in the goals of panels may explain why, overall, they don't appear to provide benefit in improving the system.[15]

The U.S. Department of Health and Human Services' leadership is this year calling for stronger medical review panels as one part of reforming the medical litigation system: "Boards with special expertise in the technical intricacies of health care can streamline the fact gathering and hearing process, make decisions more accurately, and provide compensation more quickly and predictably than the current litigation process. Physicians must have confidence that the legal system will get the facts right in the first place. Incentives are necessary for patients and healthcare providers to submit cases to the boards and to accept their decisions."[16]

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[12] Georgia Public Policy Foundation

[13] Georgia Public Policy Foundation

14 Michigan's Opportunities and Challenges, MSU's Perspectives, Patricia J. Fowler

[15] Physician's News Digest, "Expertise-enhancing reform of medical malpractice litigation," December 2003, by Christopher Guadagnino, Ph.D., interviewing Catherine T. Struve, Assistant Professor of Law at the University of Pennsylvania Law School and author of Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels and Other Options

[16] U.S. HHS, "Addressing the New Healthcare Crisis: Reforming the Medical Litigation System to Improve the Quality of Care," Office of the Assistant Secretary for Planning and Evaluation, March 3, 2003, http://aspe.hhs.gov/daltcp/reports/medliab.pdf.

STATE BY STATE SUMMARY

Alaska

Court appoints a three-member panel made up of medical experts within the field in controversy (A.S. § 09.55.536)[17] But Jim Jordan, Alaska Medical Association Director, asma@alaska.net, says that the panel in Alaska has been effectively non-functional for about five years for a myriad of reasons. Long-time Alaska attorney Ken Roose in Anchorage said the panel system is "a total failure." "There hasn't been a medical review panel convened in this state in probably 10 years because the doctors refused to participate. You'd think with tort reform that would be something the doctors would jump at as a chance to screen these cases." When lawyers asked for panels and judges then went to find physicians to serve on them, no one would, according to Roose. The judges threw up their hands. They hadn't any means of forcing physicians to participate. Legislation now being attempted looks only at lowering caps on non-economic damages. Alaska was in the 1970s self-insured in response to the medical malpractice crisis of that era, but liquidated its thriving medical malpractice program in the 1980s because there were plenty of insurers in the market. Once the accumulated funds were spent by the insurer contracted with to provide insurance to physicians in the state (free of charge), another medical malpractice insurance crisis developed.[18]

Arizona

Arizona had in place screening panels for a number of years until the plaintiff trial attorneys figured out a clever way to make them work against physicians, according to Chic Older of the Arizona Medical Association (email, 8/31/04, chicolder@azmedassn.org). "At that point, even the medical profession supported a bill to eliminate them. Our legal counsel is looking for successful working examples of panels to determine if it will be a part of our reform package. I have heard that Michigan may have a good system and we will take a look. In concept, it is a good way to go, and most important, if properly constituted can discourage frivolous cases."[19]

Connecticut

In the mid 1980s, the nation received warnings about a medical malpractice crisis then brewing. A number of states implemented legislation in response to this perceived problem. Although Connecticut did not implement reforms as extensive as some other states, it did create a medical malpractice pre-trial screening panel (CGS § 38a-32). Use of the panel depends on the consent of the parties. In accordance with the party's mutual agreement, the insurance commissioner or her designee selects panel members from lists of names submitted by the Connecticut State Medical Society and the Connecticut Bar Association. The panel is composed of two doctors and one attorney with trial experience in personal injury cases, who acts as chairman. One of the doctors must practice in the same field of specialty as the defendant. Panel members should not be from communities in which the defendant doctor or the parties' attorneys maintain their practice. Panel members are not compensated. The panel holds confidential hearings when and where it decides; transcripts are available at cost to either party. The panel's conclusion as to liability is set forth in a finding signed by the members and recorded by the Insurance Commissioner. The panel does not address the issue of damages. Each party receives a copy of the panel's findings. If a subsequent trial is held, only unanimous findings of the panel are admissible. The trier of fact

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[17] MMA by Michael Ahearn

18 Ken Roosa, Cooke, Roosa & Valcarce, Box 409, Bethel, Alaska, 99559, (907) 543-2744

[19] Chic Older is the Executive Vice President of the Arizona Medical Association. Prior to becoming ArMA's top executive in 1989, Chic served as ArMA's Director of Government Affairs for five years. From 1974 to 1984, he worked for the Arizona Hospital Association, now known as the Arizona Hospital and Healthcare Association. Older has a master's degree in health care administration from George Washington University in Washington, D.C. (http://www.azmedassn.org/staff.html)

(court or jury) determines the weight assigned to such admissible findings. No member can be compelled to testify.[20] According to George Coppolo of the Connecticut Office of Legal Research, there have been an average of 350 medical practice cases annually in that state for the last 15 years. *The purely voluntary screening panel system is unused*. "No one wants an extra step," Coppolo said. A comprehensive bill including a mandatory court screening process for medical malpractice cases, among other tort reform provisions, was passed by the 2003 Connecticut Legislature. Governor John Rowland vetoed the bill due to the absence of a cap on non-economic damages.[21]

Delaware

Under Delaware Title 18, Insurance Code, Part I, Chapter 68, Health Care Medical Negligence Insurance and Litigation, Subchapter III, Medical Negligence Review Panels, each medical negligence review panel convened in an action is composed of five voting members (two health care provider members -- a physician and one from the health care disciplines involved in such action, one attorney and two lay persons who are not health care providers nor licensed to practice law nor associated with the insurance industry). The attorney member acts as panel chairperson and presides at all meetings. The Insurance Commissioner designates one member of the Commissioner's staff to sit as a nonvoting ex officio member of the panel, with custody of and responsibility for the keeping of all evidence, records and related material used by the panel.[22] Deputy Attorney General Michael Rich, lawyer for the Delaware Insurance Department, said he served on the last medical negligence review panel convened in Delaware in 1976.[23] Claimants and respondents do not want to spend the time and money to use the panels. The medical negligence review panel was created in response to medical malpractice issues that arose in the 1970s but nothing was resolved by instituting panels because though cases went through the process, settlements were not prompted. "The other reason it has not been used in 20 years or more is because in 1983, the Delaware Superior Court that has jurisdiction over medical malpractice put in an arbitration and mediation procedure so now whether a case is contract or medical malpractice related, they all get referred for mediation, and the mediation process tends to accomplish what was intended" by the Insurance Department law. Rich says that the arbitration and medication process "creates an opportunity to vet the case for possibility of settlement and if it doesn't, then you go through discovery process and go to trial." The Superior Court's change in rules nullified the need for the panels, but "the law stays on the books nonetheless." Superior Court spokesman Maureen Fredericks said that there were 74 medical (and a few legal) malpractice suits filed last year, and 97 were disposed of, 124 were pending and 83 were tried in a civil trial. She noted that cases claiming more than $100,000 in damages are arbitrated while cases of more than that amount proceed to trial.[24]

Florida

Florida law requires a pre-suit investigation (766.203) prior to filing a claim for medical malpractice. Florida has a unique system of voluntary arbitration that gives incentives to both parties. The system is used for the determination of damages. The defendant gets to limit damages in return for admitting liability. The plaintiff therefore has a guaranteed payout. If the defendant refuses arbitration, the plaintiff may receive up to 25 percent of the award in attorney's fees if he wins (Fla. Stat. Ann § 766.209). If the plaintiff refuses arbitration, he will only be able to recover economic damages (80 percent of lost wages) and no more than $350,000 in non-economic damages. If the plaintiff accepts arbitration, he may only receive 80 percent of lost wages for economic damages and the recovery cap for non-economic damages is lowered to $250,000 with attorney's fees of 15 percent. The damage cap has been held to be constitutional.[25] There have been no formal studies of the effects of the pre-suit system in Florida. "Honestly, it has not slowed down the competent plaintiff's attorney, just added to the costs of the case," according to the Florida Medical Association's Associate General Counsel Jeff Scott. "The

[20] Connecticut Office of Legal Research, Jerome Harleston, Senior Attorney, April 29, 2003, "Medical Malpractice Pretrial Screening Panels, 2003-4-0401, http://www.cga.state.ct.us/2003/olrdata/ins/rpt/2003-R-0401.htm.
[21] Telephone call, Sept. 16, 2004, 2 p.m., George.Coppolo@po.state.ct.us
[22] Delaware Legislature, State Code, http://www.delcode.state.de.us/title18/c068/sc03/index.htm#TopOfPage.
[23] Telephone conversation 9/23/04
[24] Telephone call, 9/24/04, (302) 255-0798
[25] Michael Ahearn

pre-suit affidavit requirement is easy to deal with, there is no shortage of doctors willing to sign garbage affidavits. The arbitration system has not worked well in practice and is only offered now in the most egregious of cases. As malpractice rates in Florida are the highest in the nation, it obviously has not worked as well as was hoped for. Nonetheless, we are trying to fix the system rather than ditching it completely."[26]

Georgia

The Georgia Public Policy Foundation recommends that the Georgia General Assembly enact a mandatory medical malpractice panel system (MMRP). "It would provide a fair means of decreasing litigation costs and insurance premiums. The number of claims that go to trial would be reduced and plaintiffs would still keep the judicial system as the final forum. The MMRP's conclusion should include a determination of the case's merits (either yes or no) and an assessment of any damages. Nonbinding MMRPs would not prevent plaintiffs from seeking a jury trial if they so desired, and a substantial improvement provision could require both sides of the dispute to carefully consider the prudence of litigation. Lastly, permitting the panel's conclusion to be admitted at trial would enhance the fairness and effectiveness of the system and would provide courts another source to assist in evaluating scientific issues."[27] The Public Policy Foundation's advice was not heeded, according to attorney Mac Gibson, author of the recommendation and a Policy Foundation member: "Thank you for your interest in MMRPs. The Georgia General Assembly has not yet addressed the issue. So, unfortunately, there is no reference. There is a possibility the issue will come up for vote next year. This issue has been receiving some attention in local newspapers and from the Governor's office. Good luck in addressing new, creative ways to fairly and equitably reform our judicial system."[28]

Hawaii

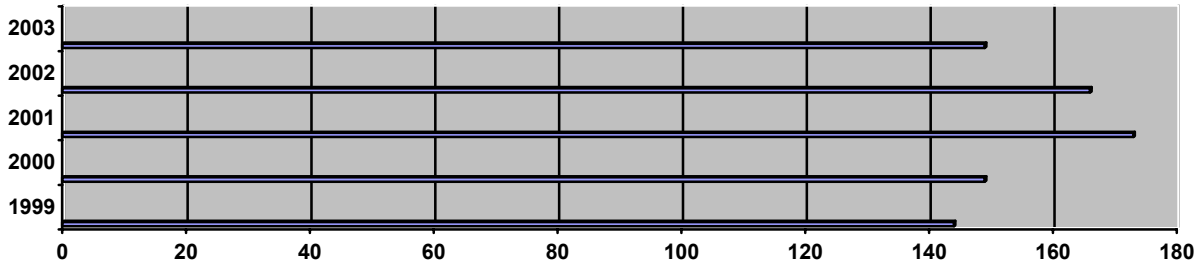
The State of Hawaii Department of Commerce and Consumer Affairs Office of Administrative Hearings operates a Medical Claims Conciliation Panel that hears all medical malpractice complaints against physicians, osteopaths, surgeons and hospitals. The panel is composed of an attorney, a doctor and a chairman. Hawaii also offers claimants nonbinding arbitration in personal injury cases of less than $150,000. There are not a lot of medical malpractice cases in that program because most medical malpractice claims are more than $150,000.[29] Rod Maile in the Department of Commerce and Consumer Affairs, 808-587-8633, is in charge of the Medical Claims Conciliation Panel. The Medical Claims Conciliation Panel was established 20 years ago by Act 219, 1976 Session Laws of Hawaii, Hawaii Revised Statutes ("HRS") §671-11. The program is responsible for conducting informal conciliation hearings on claims against health care providers before such claims can be filed as lawsuits. The decisions of the panel are advisory in nature and are not binding on the parties, in the event that any party still wishes to pursue the matter via the courts. The real value of the panel programs is demonstrated if the parties make conscientious and thorough presentations to the panels. In such cases, the decisions rendered by the panels provide the parties with fairly accurate advisory determinations of the relative merits of the claims, which should assist the parties in evaluating whether the claims should be pursued through the judicial system. The program also provides opportunities for the parties to exchange information in a relatively expedited and inexpensive manner, which in turn provides for opportunities for the parties to explore the conciliation of meritorious claims prior to such claims being brought before the courts. The requirements of exchanging information between the parties, and making conscientious and thorough presentations to the panels, discourage the pursuit of frivolous or fraudulent claims, prior to further legal proceedings being taken by the parties.[30]

In 2003, Hawaii amended its laws to require potential medical malpractice claimants to first obtain certificates of consultation. "You have to make an effort to consult with the physician or a physician in a closely related specialty," Maile said, "so potential claimants and their attorneys would have at least the responsibility to get a better understanding

[26] Email, jscott@medone.org, 9/15/04
[27] Georgia Public Policy Foundation
[28] Email from Mac Gibson sent 8/16/04, MGibson@alston.com.
[29] Hawaii State Judiciary Center for Alternative Dispute Resolution Director, telephone call, 9/22/04, 808-539-4237.
[30] http://www.hawaii.gov/dcca/oah/other.html

of what the underlying claim is about – consultant doesn't have to be an expert witness or identified: (Section 671 – 11 et seq.). Parties to medical malpractice claims also, as of 2003, may substitute an alternative dispute resolution process (with prior approval) for the Medical Claims Conciliation Panel.[31]

Claims filed in 1999 through November 30, 2003, in the State of Hawaii Office of Administrative Hearings



	2003[32]	2002[33]	2001[34]	2000[35]	1999[36]
Hearings held	**101**	**100**	**99**	**99**	**129**
Actionable negligence found	**13**	**6**	**6**	**15**	**42**
Some respondents negligent		**4**	**10**	**5**	**5**
No negligence found	**76**	**79**	**81**	**76**	**78**
Panel decision pending	**7**	**3**	**2**	**2**	**3**
Dismissed by panel	**5**	**8**		**1**	**1**
Total damages recommended	**$3,160,000.00**	**$657,500.00**	**$11,652,849.54**	**$982,202.00**	**$17,204,000.00**

Idaho

Idaho law requires all claims to be presented to an informal and non-binding hearing panel that is established by the Idaho State Board of Medicine. The findings are not admissible in any subsequent civil action (Idaho Code § 6-1001 to 6-1011).[37] Statistics in the Board of Medicine Spring 2004 newsletter show that more than two-thirds of claims result in a finding of "without merit" in pre-litigation screening.

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Hearing requests	**84**	**75**	**96**	**126**	**115**	**130**	**122**	**156**	**178**	**158**	**140**
Number of defendants	**155**	**152**	**182**	**210**	**223**	**207**	**191**	**304**	**348**	**269**	**242**
Hearings completed or settled									**137**	**253**	**139**
Findings											
Without merit	**43**	**64**	**61**	**57**	**57**	**91**	**69**	**81**	**78**	**165**	**92**
With merit	**3**	**7**	**13**	**20**	**17**	**29**	**17**	**14**	**23**	**31**	**30**
Some/possible merit	**10**	**3**	**5**	**8**	**2**	**11**	**8**	**15**	**15**	**25**	**4**
Withdrawn/dismissed/stld	**18**	**13**	**24**	**17**	**14**	**19**	**14**	**17**	**20**	**32**	**13**

In the 1986-87 Idaho Law Review published by the College of Law at the University of Idaho, an article was published reviewing the Medical Malpractice Act's first 10 years. The Law Review reported that in 1986, the Idaho State Board of Medicine, the Idaho Medical Association and the Idaho Hospital Association completed a survey of defense counsel on

[31] Telephone conversation, 9/22/04
[32] The Medical Claims Conciliation Panel and the Design Professional Conciliation Panel Annual Report to the 2004 Legislature, State of Hawaii, Department of Commerce and Consumer Affairs, Jan. 1, 2003 through Nov. 30, 2003
[33] MCCP and DPCP Annual Report to the 2003 Legislature
[34] MCCP and DPCP Annual Report to the 2002 Legislature
[35] MCCP and DPCP Annual Report to the 2001 Legislature
[36] MCCP and DPCP Annual Report to the 2000 Legislature
[37] Michael Ahearn

the pre-litigation screening panels from January 1981 through April 1985. The survey sought to determine whether the panel procedure was performing effectively and whether it was adequately serving the medical care industry. The information also was accumulated to determine whether pre-litigation panels should be supported, changed or abolished. The findings were favorable to panels.

The statistic rendered that seemed most significant was that 265 healthcare providers who had patients sufficiently upset with their medical treatment to initiate a panel proceeding or see a lawyer about a panel proceeding avoided being named as defendants in medical malpractice lawsuits. The claims against them were handled confidentially, informally, and possibly without public awareness. Their cases simply disappeared following the pre-litigation proceedings. This was ruled by the authors to be consistent with the intent and purpose of the pre-litigation screening panel process. For the 265 healthcare providers who were not sued, some cases were settled or dropped as a result of the panel proceedings. Seventy of these defendants were involved in settlements. This result is also consistent with the intent and purpose of the pre-litigation screening process – fostering settlement in cases of probable merit prior to litigation. The statistics further reveal that 242 healthcare providers eventually did have lawsuits filed against them following the pre-litigation process. Of those, 54 following panel proceedings that resulted in a finding of merit in connection with the claimants' allegations. Another 188 cases were found to be without merit by the panel, but nonetheless resulted in lawsuits. The panel's decisions were not infallible, and in some cases which the panel determined to be without merit were later resolved in favor of the claimant. Regardless, the resolution of 52 percent of the cases without suit being filed indicates the probably effectiveness of the pre-litigation process as an alternative dispute resolution mechanism, the authors say. The survey showed that 70 cases were settled before litigation was filed, 15 before the panel hearing and 55 after the hearing.

The panel process may have played a significant role in achieving those settlements. The panel also may have given the parties a better opportunity to understand their respective positions and evaluate their cases prior to litigation. Idaho's pre-litigation panel procedure probably has exceeded any expectations that may have existed at the time it was passed. It has resulted in the confidential resolution or withdrawal of a significant number of malpractice cases that otherwise would have further burdened Idaho's already overburdened court system. It is inexpensive, expeditious and provides the patient with a free, unbiased review of his or her medical care complaint. The Idaho structure could serve as an effective model for other states seeking an efficient and inexpensive system for pre-litigation review of cases of any type – regardless of whether the review is limited to medical malpractice claims or expanded to other types of claims.[38]

Indiana

Indiana law mandates a review panel for medical malpractice actions where the amount in controversy is over $15,000 unless both parties waive this option in writing (Ind. Code Ann. § 34-18-8-4 to 34-18-8-6). The panel, which consists of one attorney and three healthcare providers, issues an expert opinion as to whether the defendant failed to comply with the standard of care (Ind. Code. Ann. § 34-18-10-2, § 34-18-10-22). The opinion is not conclusive but is admissible in subsequent litigation (Ind. Code Ann. § 34-18-10-23).[39]

Please be advised that the Medical Review Panel process is being utilized here within the State of Indiana. The Insurance Department, which administers the Patient Compensation Fund, is unable to provide timeframes on how often the panels meet due to the Department not being involved during the panel process. The Department only acts a file repository with respect to keeping records as to who made the request for formation of a medical review panel, who the panel chairman and panel members are and the opinion rendered. Below is a portion of an annual report as of year-end 2001-2002 that the Insurance Department compiles with regard to complaints filed and panel decisions rendered. At this time the Insurance

[38] Medical Malpractice Law in Idaho: An Update, by Richard E. Hall (AB, 1966, University of Idaho, JD, 1969, Harvard Law School, member of Idaho State Bar and malpractice consultant for Physicians Management Magazine, private practice shareholder with the firm Moffatt, Thomas, Barrett and Blanton chartered in Boise, Idaho) and Candy Wagahoff Dale (BS, 1979, College of Idaho, JD, 1982, University of Idaho College of Law, member of the Idaho State Bar, private practice shareholder with the firm Moffatt, Thomas, Barrett, and Blanton), Idaho Law Review, College of Law, University of Idaho, Volume 23, 1986-87, Number 2.
[39] http://www.in.gov/legislative/ic/code/title34/ar18/ch10.pdf

Department is unable to provide any updated information due to going through a software change. This information may be available in the near future.[40]

Year	Number of Complaints Filed	Number of PCF Payments	Number of Complaints with Panel Opinion Rendered Each Year	Panel Decision			
				Malpractice	No Malpractice	Material Issue of Fact	Variation of Opinion
1975	1	0	0	0	0	0	0
1976	18	0	1	1	0	0	0
1977	141	0	3	1	2	0	0
1978	272	3	17	4	13	0	0
1979	318	8	40	6	33	1	0
1980	400	11	69	9	56	1	3
1981	431	7	118	16	94	4	4
1982	555	24	123	25	84	7	7
1983	626	35	173	27	133	10	3
1984	687	57	205	43	143	13	6
1985	780	36	279	43	219	10	7
1986	683	90	278	62	186	10	20
1987	666	99	280	60	191	23	6
1988	647	71	326	62	234	14	16
1989	691	68	301	73	196	17	15
1990	693	105	349	79	232	25	13
1991	764	131	298	63	197	26	12
1992	867	105	378	82	257	22	17
1993	842	101	445	117	272	40	16
1994	862	141	519	133	319	44	23
1995	1028	134	464	114	289	47	14
1996	931	120	490	116	309	40	25
1997	976	119	450	113	288	40	9
1998	889	139	449	143	258	40	8
1999	879	146	452	132	270	34	16
2000	969	203	484	138	306	29	11
2001	1150	181	937	194	613	32	98
2002	1105	181	Not yet available	Not yet available	Not yet available	Not yet available	Not yet available
Total	18,871	2,315	7,928	1,856	5,194	529	349

Kansas

Kansas's law does not mandate but allows either party or the judge to submit the case to a medical screening panel. The panel's opinion is admissible in subsequent court proceedings and either party may call the panel members as witnesses (Kan. Stat. Ann. § 65-4901, 65-4904).[41] Supreme Court Rule 142 (1998 Kan. Ct. R. Annot. 179) also plays a role in screening panel procedure, compensation, and expenses. Rule 142(c) provides that compensation and expenses of panel members "shall be as provided in K.S.A. 65-4907." (1998 Kan. Ct. R. Annot. 180.) A medical malpractice screening panel has three health care members and one chairperson. K.S.A. 65-4901. Each health care member is to receive $250 for all work performed (the chairperson of the panel, an attorney, receives $500). K.S.A. 65-4907(a). The costs are directed by

[40] October email from Annette Gunter, Patient Compensation Fund Manager, Indiana Department of Insurance, 311 West Washington Street, Ste. 300, Indianapolis, IN 46204, (317) 232-2401, Agunter@doi.state.in.us

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the legislature to be paid by the side in whose favor the majority opinion is written. If the panel makes no recommendation, each side is responsible for paying one-half of the costs. K.S.A. 65-4907(b).[42]

Either party can request a screening panel, each chooses a physician, and they mutually agree on a third or the third is picked by a judge. The panel looks at medical records only. The panel decides whether the standard of care has been met and the panel's result is admissible at trial. I don't know that we've seen a big impact on medical malpractice premiums resulting from the existence of the panel option. I think you see it more used by the plaintiffs attorneys who want to get rid of cases and say to their client, "Why don't we do a screening panel?" It helps get rid of a few frivolous cases that maybe even plaintiffs attorneys think are merit-less. But there's really no way to track panels' impact. We don't use them on the defense side that much. After all, they're not a final resolution for cases.[43]

Kentucky

Sen. T. Buford pre-filed a bill in 2004 that would have created a medical malpractice screening panel in Kentucky to review each case of alleged medical malpractice prior to the filing of any civil suit in the General Assembly.[44] The proposed measure would have required the panel to issue an opinion in each case of alleged medical malpractice regarding whether the evidence supported the conclusion that a healthcare provider committed medical malpractice. The opinions in each case were to be admissible as evidence in court but not a conclusive determination in court proceedings on whether medical malpractice was committed. A Constitutional Amendment would have been required for the panels to be set up. The measure was introduced and died.[45] "The trial attorneys were a lobby to oppose the bill and said it would slow the process to a trial," Sen. Buford said. "They had other objections, but I feel they wanted to reform to the jury awards. I feel this is necessary to slow med mal and to prevent the 400+ doctors that left Kentucky in the past two years. Med mal premiums are too high for certain professions on MD."

Louisiana

Louisiana law requires a medical review panel to review all malpractice claims. Louisiana also allows patients to enter into arbitration agreements. The medical panel does not review cases that go to arbitration. The medical review panel, which consists of one attorney and three physicians, determines if defendants failed to comply with the standard of care and whether defendants contributed to the injuries. The panel's report is considered as an expert opinion in subsequent litigation. Also, any party may call a member of the panel as a witness. (La. Rev. Stat. Ann. § 40:1299.47, 40:1299.47(A)).[46] The constitutionality of the Louisiana panel was challenged in 1978 and the Louisiana Supreme Court ruled it constitutional. The court stated, "The valid state purpose served by the two provisions of the medical malpractice act before us is lowering the cost of health care generally and the assuring of available medical care for the citizens of the state. We cannot say the two challenged provisions of the act adopted by the legislature represent an unreasonable response to the medical malpractice problem. Nor are the provisions especially far reaching."[47] The Louisiana Patient's Compensation Fund reported that from 1987 to 1996, there were 535 decisions for the plaintiff and 6,586 decisions for the defendant. An additional 3,324 cases were either settled voluntarily, were dismissed, or were abandoned. In Louisiana the total fees paid for a single panel cannot exceed $2,750 ($2,000 per attorney, chairman, $250 per physician). These costs do not reflect the fees charged by plaintiff and defense lawyers in preparing the case for a panel review.[48]

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42 http://www.kscourts.org/kscases/supct/1999/19990305/80792.htm, Kansas Supreme Court, Johnson v. Mehta and St. Joseph Hospital, Cloud County Health Center, Inc., Syllabus By The Court

43 Catherine Walberg, JD, Vice President & General Counsel, KaMMCO/MSC (Kansas Medical Mutual Insurance), (785)-232-2224, telephone conversation on 12/2/04.

44 Email, 8/26/04, tom.Buford@lrc.ky.gov

45 Kentucky Legislature, http://www.lrc.state.ky.us/home.htm

46 Michael Ahearn

47 Dr. William W. Kridelbaugh, M.D., FACS, Albuquerque, N.M., and Donald J. Palmisano, M.D., FACS, Metairie, LA.

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Maine

Mandatory Pre-Litigation Screening Panel review of all medical professional liability claims is required under Maine's Health Security Act. The Act establishes much of the law and all of the relevant procedures governing medical malpractice litigation in Maine. This panel process is a mandatory but non-binding form of alternative dispute resolution for malpractice claims. The purpose of the panels is to identify claims of professional negligence which merit compensation and encourage early resolution of those claims prior to litigation; also the intent is to identify non-meritorious professional negligence claims, encouraging early withdrawal or dismissal. The Health Security Act was enacted in 1977. By amendment, mandatory pre-litigation screening of malpractice claims became part of the act in 1985.[49]

Any patient who intends to formally litigate a claim for professional negligence against a Maine-licensed healthcare provider must follow the statutory process of dispute resolution mandated by Maine's Health Security Act. If all parties agree to a written waiver of the panel process, formal litigation may commence immediately in Superior Court. The Chief Justice of the Superior Court is responsible for maintaining a pool of qualified individuals to serve as panel chairmen. Retired judges and others with some judicial (or mediation) experience make up this pool. The Clerk of Court provides the Chair with lists of healthcare practitioners and attorneys that would qualify as potential panel members. The Chair chooses one attorney and one practitioner. The Chair strives to choose a practitioner who is in a specialty relevant to the claim, often seeking advice from the Maine Medical Association. Dispositive affirmative defenses and motions relating to discovery may be referred by the Panel Chair to the Superior Court for rulings prior to the submission of the case to the panel. An example of an affirmative defense would be the apparent expiration of the three-year statute of limitations prior to the initiation of the claim. The Superior Court judge would rule on a motion to dismiss before extensive discovery is conducted in preparation for a panel hearing.[50]

Panel hearings take place on average between 12 to 18 months following the initial claim notice. This timeframe is much more finite than litigation. The claimant, the accused healthcare providers and their respective counsel generally attend hearings. Depositions are admissible at the hearing. Customarily, the parties' experts personally attend. The panel will have access to the complete medical record and deposition transcripts. The Panel Chair presides over the hearing in a judicial role, making all procedural rulings that are final. Panel members may pose questions of the witnesses. The Maine rules of evidence do not apply. Instead, the standard applied is that evidence must be admitted if it is the kind of evidence upon which reasonable persons are accustomed to rely in the conduct of serious affairs. The standard of proof the claimant must meet is to prove negligence and proximate causation by a preponderance of the evidence. If the panel is unanimous against the provider, the findings are admissible in any subsequent court action rising out of this same claim. If the panel is unanimous against the claimant, this finding too is admissible in any subsequent court action arising from the same claim.[51]

The Health Security Act strongly urges the parties to a claim to accept unanimous panel findings as dispositive decisions. This means when the decision is favorable to the plaintiff, the defendant provider should enter settlement discussions to resolve the claim. When the panel unanimously answers in favor of the defendant provider, the plaintiff should dismiss the claim. Regardless of the decision of the panel, whether split or unanimous, the parties are not bound by that decision. The plaintiff may elect to pursue litigation in Superior Court should the matter not settle or should the claimant disagree with the panel findings.[52]

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[49] Medical Mutual Insurance Company of Maine, Michael McCall, Vice President, Claims and Risk Management, "The Medical Mutual Advocate," Third Quarter 2002 and January/February 2003, www.medicalmutual.com
[50] Medical Mutual Insurance Company of Maine, "The Medical Mutual Advocate"
[51] Medical Mutual Insurance Company of Maine, "The Medical Mutual Advocate"
[52] Medical Mutual Insurance Company of Maine, "The Medical Mutual Advocate"

"It has been Medical Mutual's experience that unanimous findings by the panel are indeed dispositive. In the 16 years since the panels went into effect, Medical Mutual elected to defend through a jury trial only two claims in which the Panel findings were unanimously unfavorable to the insured defendant. Both cases were won at trial. The entire process, including the initial claim notice, all pleadings, all depositions, the Panel hearing and the panel findings are confidential. The exception is when the Panel findings are unanimous and there is a subsequent court trial. The unanimous findings will be admissible at trial and therefore available to the public.[53]

Maryland

The Health Claims Arbitration Office was established in 1976 (Chapter 235, Acts of 1976). For medical injury malpractice claims in excess of $25,000, the Office provides a system of mandatory arbitration. Each medical malpractice claim is heard by a three-person panel, including an attorney, health care provider, and member of the public. The panel determines who is liable with respect to the claim and, if a health care provider is liable, considers and assesses damages. To reverse or modify the award, the rejecting party must file an appeal with the Circuit Court. *Any party wishing to waive the arbitration process and proceed at the Circuit Court level may elect to waive arbitration and file a complaint at the appropriate Circuit Court. If the parties mutually agree, the courts may refer health care malpractice claims to the Health Claims Arbitration Office for the purpose of neutral case evaluation* (Chapter 458, Acts of 1999). In this process, the Director supplies a list of qualified evaluators to all parties. During the evaluation period, the Circuit Court maintains jurisdiction. The Director is appointed by the Governor with Senate advice and consent (Code Courts & Judicial Proceedings Article, secs. 3-2A-01 through 3-2A-09).[54]

Year	Cases filed	Panel closing	Non-panel closing	Arbitration waived	Total closed	Total open
1977	2	2	0		2	0
1978	93	41	52		93	0
1979	269	104	165		269	0
1980	326	124	202		326	0
1981	428	177	251		428	0
1982	462	207	255		462	0
1983	578	215	363	1	578	0
1984	619	216	403	4	619	0
1985	702	235	467	18	702	0
1986	749	202	547	30	749	0
1987	437	160	277	46	437	0
1988	500	163	337	73	500	0
1989	590	153	437	96	590	0
1990	520	120	400	113	520	0
1991	566	158	407	138	565	1
1992	545	124	421	163	545	0
1993	659	93	566	227	659	0
1994	616	74	541	294	615	1
1995	633	54	579	379	633	0
1996	722	19	702	521	721	1
1997	696	11	683	537	694	2
1998	667	4	662	545	666	1
1999	594	6	587	436	593	1
2000	702	13	686	529	699	3
2001	707	3	702	582	705	2
2002	637	6	601	500	607	30
2003	692	0	616	558	616	76
2004	335	0	199	196	199	136
Total	15,046	2,684	12,108	5,986	14,792	254

[53] Medical Mutual Insurance Company of Maine, "The Medical Mutual Advocate"
[54] http://www.mdarchives.state.md.us/msa/mdmanual/25ind/html/42healcf.html (Maryland Health Claims Arbitration Web Site)

Massachusetts

Massachusetts's law requires all medical malpractice actions be reviewed by a tribunal consisting of a judge, attorney and physician to determine if there is an issue of liability or if the injury was an unfortunate medical result. (Mass. Ann. Laws ch. 231 § 60B). The panel's opinion is admissible in subsequent litigation. Massachusetts makes the claimant post a $6,000 bond for payment of defendants' costs if the plaintiff is not successful at trial.[55]

In Massachusetts, "every action for malpractice, error or mistake against a provider of health care" is first heard by a tribunal. "Provider of health care" includes licensed physicians, hospitals, clinics, nursing homes, dentists, registered/licensed nurses, optometrists, podiatrists, chiropractors, physical therapists, psychologists, acupuncturists, or their employees. The tribunal panel is composed of a district court judge, a physician and an attorney, unless the claim is against someone other than a physician and then he/she is replaced by a representative of that field of medicine.[56]

The physician/other healthcare professional is selected by the judge and must not be from the county where the claim is filed and must represent the field of medicine in which the alleged injury occurred. Where there are codefendants representing more than one field of health care, the judge decides who shall represent the health care field on the tribunal. The attorney (also picked by the judge) comes from a list submitted by the Massachusetts Bar. Attorneys and physicians receive $50 for their participation in the tribunals. If the panel calls an expert witness, traveling expenses and a "reasonable" fee are assessed as costs. Videoconferencing tribunals are being tested as a means of encouraging more physicians to participate in tribunals. Massachusetts General is participating by hosting tribunals using hospital equipment and meeting space. Five other hospitals were being courted in May.[57]

Each malpractice claim is heard by a tribunal within 15 days after defendant's answers are filed. If findings are made favoring defendants, plaintiffs may only pursue claims through the judicial process after filing a $6,000 bond. The bond is used to pay defendants for costs assessed, including attorneys' fees, when plaintiffs do not prevail. If a plaintiff can prove indigence, the bound amount can be reduced.[58]

Tribunals cost between $77,000 and $86,000 per year. Tribunal expenses are paid by the state, as long as the pro rata percentage does not exceed fees charged for registration of healthcare providers (minus the expenses of the Boards of Registration). No data exists to determine whether the tribunals deter medical malpractice claims or have an impact on premiums. Judgments, settlements, or other final disposition of claims at trial court level are sent to the Board of Registration in Medicine. The terms may not be sealed and are available for public inspection, although plaintiffs' identities may be kept confidential by the Board.[59]

The Massachusetts Legislature is experiencing so much pressure to deal with medical malpractice issues, they are considering legislation that would create a commission to look into the feasibility of establishing a separate court system to address nothing but medical malpractice. Proposed legislation would establish a special commission to consist of 3 senators and 4 representatives, including minority representation, the Chief Justice for Administration and Management of Trial Court or his designee, and 5 gubernatorial appointees representing the Massachusetts Bar Association, the Medical Society, and Trial Attorneys, and a consumer (who is not a doctor or lawyer). The commission would be authorized to conduct an investigation into the feasibility of creating a specialized court for purposes of administering medical malpractice claims, considering specialty courts within Massachusetts, efficiencies to be gained, expertise and training

[55] Michael Ahearn
[56] Dana Leavitt, Commonwealth of Massachusetts, The Superior Court, J.W. McCormack Post Office and Courthouse, 90 Devonshire Street, Room 1517, Boston, MA 02109, (617) 788-7305
[57] Dana Leavitt, Commonwealth of Massachusetts, The Superior Court
[58] Dana Leavitt, Commonwealth of Massachusetts, The Superior Court
[59] Dana Leavitt, Commonwealth of Massachusetts, The Superior Court

needed by jurors and jurists, use of information technology, use of medical legal advisory panels, use of regional sites, and court staffing needs.[60]

Michigan

Michigan enacted a voluntary arbitration program called the Michigan Medical Malpractice Arbitration Program in 1975. The Michigan program required that at or near the time of treatment, hospitals, insured by companies licensed to write malpractice policies in Michigan, offer patients the opportunity to sign agreements to arbitrate any further disputes arising out of the care or treatment provided. Although not required, self-insured hospitals and healthcare providers could offer arbitration agreements as well. Participation was voluntary and arbitration agreements would cover a single admission that could be revoked within 60 days of discharge. Patients who did not sign an initial arbitration agreement could request arbitration if malpractice did arise. Cases were heard by a three-person panel consisting of an attorney, healthcare provider and a layperson. Panel decisions were based on a majority ruling and were binding. The U.S. General Accounting Office (GAO) conducted an analysis of the program in 1990. GAO found that the program had an extremely low participation rate and therefore made it difficult to determine its effect on medical malpractice insurance rates. However, GAO found that those claims it did resolve took less time to resolve and generally resulted in lower awards. Because of lack of consumer interest, the program is no longer operational.[61]

Michigan law now requires mandatory review of all medical malpractice actions before a mediation panel. The panel has 14 days to determine standard of care. A party may reject the opinion, but must pay the opposing party's actual costs if there is an unfavorable verdict. The parties may also agree to binding arbitration if the amount in controversy is less than $75,000.[62]

Michigan tort reforms are in many respects more stringent than suggested federal measures. Michigan legislation is modeled after the California Medical Injury Compensation Reform Act of 1975, considered the standard for medical tort reform. Strict filing requirements, damage caps and expert witness requirements are among the significant changes included in the 1993 Michigan Tort Reform Legislation that amended Public Act 78. Judicial debate over interpretation and application of the statute continues. Despite tort reform legislation, Michigan medical liability premiums exceed other states. Medical Liability Monitor publishes an annual survey comparing insurance rates for three medical specialties. The 2002 report includes a comparison of premiums for the specialties in the nineteen states that have non-economic damage caps.[63]

One of the problems in insurance rating systems is that premiums are not based on the experience of an individual physician or provider. Instead, the rates for a given group are the same for all members of the group. Premium discounts for physicians who have never been sued are negligible in the current market. Rather than impose a surcharge for physicians with large litigation losses, insurers opt for non-renewal of the policy. Passage of Michigan House Bills 5684 and 5934, introduced in 2002, could erode the reforms legislated in 1993. Respectively, these bills call for exceptions to the non-economic cap and removal of provisions that limit recovery for loss of chance or opportunity to survive or achieve a better result.[64]

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[60] Dana Leavitt, Commonwealth of Massachusetts, The Superior Court
[61] National Governors Association Center for Best Practices, Issue Brief, December 5, 2002, Health Policy Studies Division, Emily V. Cornell, (202) 624-7879
[62] Michael Ahearn
[63] Michigan's Opportunities and Challenges, MSU's Perspectives, Patricia J. Fowler, Director, Risk Management and Insurance, Michigan State University
[64] Michigan's Opportunities and Challenges, MSU's Perspectives, Patricia J. Fowler

Montana

Montana law requires all medical malpractice claims not under an arbitration agreement to be reviewed by a medical panel before filing a complaint. Although the panel's opinion determines whether the defendant is liable for malpractice, the decision is not binding and is not admissible in court (Mont. Code Ann §§ 27-6-105, 701, 692, 606, 704).[65]

"There's been a significant decrease in court cases to less than two a year. We're one of the four best states relative to frequency," according to the Montana Medical Legal Panel's director, Brian Zin. There has been a downward trend in the absolute number of lawsuits, slightly higher numbers of jury trials, fewer appeals -- which accelerated downward after the enactment of the "cap" on non-economic damages -- with an increase in the number of claims of malpractice involving increasing numbers of physicians, Zin reported in February 2004. Because of their smaller numbers and their later involvement in the panel as of late 1987, dentists in lawsuits constituted only 1.8 percent of the total providers in lawsuits, insufficient to determine trends. Podiatrists were not added to the panel until late 1997 and through 2000, no claims involving podiatrists led to lawsuits. From 1977 to 2000, physicians constituted the predominant number of providers with claims, and they have larger numbers, there being 2,875 physicians with claims, hospitals next with 982, then long-term care facilities at 507, ending with 81 dental claims and 4 podiatry claims, the latter two having entered the panel system at a later date than physicians and hospitals. None involved jury trials and none involved appeals.[66]

Overall, through 2003, the major components of medical malpractice claims and the rate of those claims per 1,000 healthcare providers (or per 1,000 hospital beds in the case of hospitals), shows a small proportion of claims where a lawsuit is filed, with even a smaller proportion involving jury trials, and only four jury trial awards of $1 million or more, Zin says. Appeals, which primarily involved procedural issues and issues of whether a judge's summary ruling without a jury trial was appropriate were also shown. Three cases involving six physicians since 1977 have involved reversals of jury trial verdicts in favor of physicians, with no other types of healthcare providers having these type of results.[67]

Nebraska

Nebraska law used to require all medical malpractice actions be reviewed by a medial panel before filing the complaint. The panel determined if the defendant complied with the standard of care and whether the damage suffered was the proximate cause of the defendant failing to act within the standard of care, according to the Nebraska Medical Association's attorney. "When the act was first put in place in 1976, medical review panels were required in the hope that an independent review would settle a lot of cases. That didn't work out. After a dozen years or so, the plaintiffs and defense attorneys agreed to make it optional rather than mandatory and it's used now, but only sparingly. There are several cases a year but usually when it's used, it's used for a different purpose than originally intended. It holds the statute of limitations. If a plaintiff is close to the deadline but not really ready to file a case, he/she can file for a review panel. That stops the statute of limitations from running out. It provides a chance to stall. Even though medical review panels are highly touted in some states, we didn't find them to be of value here. But I think we made a mistake when we made it optional even though the plaintiffs and defense lawyers didn't care for them. They provided the doctors with some degree of comfort that they weren't going to trial without an independent review. After the passage of Nebraska's reform package, medical malpractice insurance went from being nearly unavailable to very – Nebraska is fourth or fifth lowest in the nation for insurance rates. It was the fund with a lid that made the rates go down, not the medical review panels. But I think you should try it. Some states found it successful. There was just something for us that didn't prove to be successful."[68]

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[65] Michael Ahearn

[66] Brian Zin, Director, Montana Medical Legal Panel, 2021 11th Ave. Suite 1, Helena, MT 59601, (406) 443-1110, Montana Medical Legal Panel, Claims, Settled and Dropped Claims, Lawsuits, Jury Trials and Appeals in Montana Medical Liability Cases, 1977-2003, February 27, 2004

[67] Brian Zin

[68] Charles Pallesen, Medical Association attorney, (402) 474-6900

Nevada

The Nevada Medical/Dental Legal Panel was implemented for claims filed after 1/1/86 as a mechanism to screen out frivolous lawsuits, and was discontinued in 2002. A report commissioned by the Nevada Legislature published Aug. 23, 1996, showed claim frequency dropped significantly. The volume of cases increased substantially over the period the panel operated. Growth in cases can be explained by the rapid population growth Nevada experienced over this time period. The panel was made up of volunteer physicians, dentists and attorneys. The increased volume made it difficult to schedule the panels. Cases took as long as two years to get through the panel. Panel decision-making was not binding; cases decided by the panel often went on to District Court even when there was a "no probable malpractice" decision. Plaintiff attorneys complained the delays caused hardship for their clients. Physicians complained the delays caused stress and open claims impacted the cost of their malpractice insurance. Insurance companies complained the panel process was expensive and non-binding. The panel was eliminated as part of the tort reform package that passed in the Legislature's Special Session held in Summer 2002. No attempt has been made to measure the impact of disbanding the screening panel. Physicians believe there has been an increase in frivolous claims filed since the panel was disbanded. There was a failed attempt to resurrect the panel during the 2004 session and there may be another attempt during the 2005 session. It is the Commissioner's recommendation that any new panel be made up of permanent, full-time members to avoid the scheduling problems that befell the volunteer panel.[69]

New Hampshire

The Professional Malpractice Claims Study Commission was established during the 2003 session with a reporting date of November 1, 2003. The legislation expressly directed the commission to study professional malpractice claims and include an examination of the existing pre-litigation panel, and determine how this panel could become a tool to be utilized to keep the cost of liability insurance down. The Commission received testimony that the system is not widely used and is not considered effective. In contract, the Alternative Dispute Resolution process currently in place in New Hampshire's Superior Courts has been very successful in settling most cases prior to trial. The Commission heard several presentations about the effectiveness of the pre-litigation screening panel process currently in use in Maine and Massachusetts. Benefits and disadvantages of the panel process were discussed. The commission heard testimony that the screening panel system in Maine may contribute to substantially lower percentage increases in medical liability insurance rates. Maine has recently experienced substantially lower increase in the rate of growth of medical liability insurance when compared to New Hampshire. The commission also received testimony about and discussed the constitutionality of pre-litigation screening panels. Some types have been upheld as constitutional in some states and some types have been found unconstitutional in others. The commission did not make any finding on this issue for any particular panel system that may be used in New Hampshire. The Commission concluded that the existing panel system should be repealed and re-enacted with a mechanism that provides for a more efficient way of resolving medical malpractice claims. A new system should protect injured parties, allow for the efficient use of judicial resources and help ensure that New Hampshire citizens have access to affordable medical care by reducing the costs associated with resolving medical malpractice claims, thus reducing the rate of growth in medical liability insurance premiums.[70]

New Mexico

New Mexico mandates medical malpractice claims be reviewed by a medical commission but the findings are not binding and cannot be used in subsequent court proceedings (N.M. Stat. Ann §§ 41-5-14, 20).[71]

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[69] Janice Moskowitz, Lead Actuary, Property/Casualty Section, Department of Business and Industry, Division of Insurance, 788 Fairview Drive, Suite 300, Carson City, Nevada 89701-5491, (775) 687-7270, Nevada Medical/Dental Screening Panel (Discontinued, 2002))

[70] Rep. Harry M. Haytayan, Chair, Professional Malpractice Claims Study Commission, Box 961, Hollis, NH 03049-0961, (603) 881-5293, harryh@pneutek.com, harry.haytayan@leg.state.nh.us, Draft interim report of the Professional Malpractice Claims Study Commission, November 1, 2003

[71] Michael Ahearn

New Mexico CME credits are awarded to physicians who participate in the New Mexico Medical Review Commission (medical-legal panels). Physicians earn two New Mexico specific category 1 CME credit for each panel hearing due to the educational benefits of these reviews. The Commission is the mandatory malpractice review panel consisting of volunteers from the medical and law professions. The medical-legal panels review malpractice cases before they can proceed to court. The panel has managed to ease the burden on the court system. Only 29 percent of the cases heard through the Commission are filed in court. Hearings are Monday through Thursday at 7 p.m. The average case lasts two and a half to three hours. Out of town physicians are reimbursed for travel.[72]

The New Mexico Medical Review Commission began in 1962 operates under the authority of the Supreme Court, working closely with the New Mexico State Bar. Each panel consists of three lawyers and three doctors who review medical records and literature, and hear medical testimony from the plaintiff and the defense. The panel considers whether there is substantial evidence that the act(s) complained of occurred and if so, whether they constitute malpractice and whether there is a reasonable medical probability that the patient was injured thereby. All of the panelists volunteer their time. In 2003, 495 professionals volunteered their evening(s) to attend a three- to four-hour hearing. From 1962 to 1976, there was a gradual increase in the total number of malpractice cases in New Mexico. During these years, the percentage of plaintiffs requesting a panel hearing also increased. In the mid-1970s, New Mexico experienced a crisis in malpractice insurance coverage and enacted malpractice statutes that contained provision for an obligatory screening panel hearing prior to filing a suit in any district court. The statute making the panel obligatory was enacted in 1976. The result of a panel hearing has never been transmissible to district court. The system is run by the New Mexico Medical Review Commission, an arm of the New Mexico Medical Society. It is funded by an annual appropriation from the New Mexico Legislature.[73]

From 1976 to Feb. 29, 2004, the New Mexico Medical Review committee heard cases against 4,883 providers in 3,687 applications made for a panel hearing. The total does not include 454 claims against individual providers that were withdrawn prior to hearing. The Commission has conducted 3,080 hearings involving those 4,883 providers. As to those 4,883 providers, the panels voted that 77% or 3,752 providers were not negligent; leaving 23% or 1,131 provider who were negligent, and of those 1,131, the panels determined that the negligence caused harm to the patient in claims against 757 providers. The American Physicians Assurance Corporation (APA) is the largest New Mexico medial malpractice insurer of private practitioners. According to APA data, of the 4,883 providers appearing before the Commission since its inception, APA and its predecessors covered 3,758 (77 percent), and of those 3,758 providers, the claims of 2,458 (66 percent) were never filed in New Mexico State or federal courts because they were settled or dropped. Litigation was filed against 1,085 providers, resulting in 198 involved in trials to verdict. After suit was filed, claims against 782 providers were dismissed for reasons other than summary judgment (e.g. due to settlement). The comparison of lawsuits against APA insureds by prevailing claimants versus non-prevailing patients shows that of 933 patients who "lost" before the panel, 679 (73 percent) settled, 94 (10 percent) lost by summary judgment, 135 (14 percent) lost at trial, 25 (3 percent) prevailed at trial. And of the 152 patients who "won" before the panels, 103 (68%) settled or dropped their suits, 11 (7 percent) lost by summary judgment, 24 (16 percent) lost at trial, and 14 (9 percent) prevailed at trail. The Commission's backlog is between 24 and 52 cases deep, but the Commission complies with a 60-day rule without difficulty. State statute gives the Commission a patients' compensation fund of $350,000 plus attorneys fees. The Commission has spent between $233,308 and $296,657 annually since 1999. The Commission and its staff have been sued 28 times in 17 years. The Commission's operator, Michael M. Rueckhaus, says "the volunteer professional panelists who constitute the 'commissioners' at each of our panels are the real stars of the show and to whom we owe the greatest gratitude. I constantly marvel at the willingness of the lawyers and healthcare providers to volunteer their times and make the commission a national model. This fragile system would certainly fail without the volunteer professionals."[74]

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[72] New Mexico Medical Society, www.nmms.org

[73] Dr. William W. Kridelbaugh, M.D., FACS, Albuquerque, N.M., and Donald J. Palmisano, M.D., FACS, Metairie, LA.

[74] New Mexico Medical Review Commission Annual Report Year End 2003, David Gallagher, Director, Michael Rueckhaus, Acting Director, June 2, 2004, 7770 Jefferson N.E., Suite 400, Albuquerque, New Mexico, 87109-4342, (505) 838-0237.

North Carolina

North Carolina law mandates settlement conferences for all cases that allow the parties to select their own mediator. The General Assembly has authorized a system of court-ordered mediated settlement conferences for all types of cases to be implemented in every county under rules to be drawn up by the North Carolina Supreme Court. N.C. Gen. Stat. § 7A-38.1 (Supp. 1997). Those rules, which have recently been promulgated, allow the parties to select their own mediator, but require a court order and good cause to dispense with mediation altogether. N.C. Rules, Super. Ct. Mediated Settlement Conf. Rule 1 (1997). The conference is to be held between 120 and 180 days after the answer is filed. N.C. Rules, Super. Ct. Mediated Settlement Conf. Rule 3 (1997).[75]

Court-ordered mediation has led to some out-of-court settlements, but has not lived up to its promise in North Carolina, said Thomas B. Metzloff, JD, a professor in the Duke University School of Law. The North Carolina program, enacted in 1991, is a judge-ordered step before going to court in a malpractice dispute. It has not worked better because doctors have been reluctant participants. That means that the whole point of mediation—bring disputants together to talk to diffuse their anger—'hasn't occurred in the vast majority of these cases. Of the 23 mediations observed by researchers, the doctor-defendants didn't say anything at all 14 times. Moreover, the doctors are more frequently being excused from even attending these mediation sessions.[76]

North Dakota

North Dakota requires that plaintiff and defense attorneys make a good faith effort to have the parties resolve the case through arbitration before filing a complaint. Both attorneys also must inform the parties of every alternative dispute resolution option available or be subject to sanction (N.D. Cent. Code § 32-42-03).[77] The Director of Governmental Affairs at the North Dakota Medical Association says there isn't any tracking being done: "Each case would be handled individually by a judge, who would check on compliance. It is not likely that the insurance department is able to track this either, but if you want to contact the Department, call 701-328-2440, or 1-800-247-0560[78].

Ohio

As part of its continuing efforts on behalf of Ohio physicians to resolve the professional liability crisis, the OSMA testified before the House Insurance Committee in support of House Bill 215, which will create medical expert review panels for use in medical liability cases. Under HB 215, the medical review panel will be comprised of three providers and one non-voting attorney. The medical opinion rendered by the panel would be non-binding, but admissible in court should the claim subsequently proceed to trial. HB 215 was developed based on a recommendation from the Ohio Department of Insurance's May 2003 study on the feasibility of a patient compensation fund, titled "Final Report on the Feasibility of an Ohio Patient Compensation Fund," authored by Pinnacle Actuarial Resources, Inc. At present, more than 25 states have some form of medical liability screening panel to deter against non-meritorious cases and encourage settlement of meritorious claims prior to trial. The effectiveness of review panels has been well documented in other states. In Louisiana, for example, 40 percent of the plaintiffs who lost the medical review panel subsequently dropped the case. Additionally, 48 percent of losing plaintiffs in New Mexico dropped their cases and for those who continued onto trial, the defendant physician won 95 percent of the time. Conversely, when the defendant physician lost at the panel, a negotiated settlement was reached with the plaintiff in 81 percent of the cases.[79] House Bill 215, sponsored by

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[75] McCullough, Campbell and Lane, Summary of Malpractice Law, http://www.mcandl.com/northcarolina.html

76 "Medical malpractice reform: finding a better way, New research shows no fault, arbitration and mediation each holds promise—and pitfalls," From the November 1997 American College of Physicians Observer, by Deborah Gesensway, http://www.acponline.org/journals/news/nov97/malpract.htm.

77 Michael Ahearn

78 David Peske, Director of Governmental Affairs, North Dakota Medical Association, dpeske@ndmed.com, email message 8/19/04

79 September 2003 press release, Ohio State Medical Association, 3401 Mill Run Drive • Hilliard, OH 43026, Telephone: (614) 527-6762 • Toll Free: (800) 766-6762 • Fax: (614) 527-6763

Representative Jean Schmidt (R-Loveland) contains six provisions that reform the way medical liability lawsuits are reviewed and brought to trial. These provisions include due diligence requirements when filing medical liability claims, qualifications for physicians serving as expert witnesses, and state medical board jurisdiction over out-of-state physicians serving as expert witnesses. The bill was unanimously approved by the Ohio Senate 31-0, and overwhelmingly passed by the Ohio House in early May. Governor Taft signed the bill into law on June 14.[80]

South Dakota

South Dakota does not mandate arbitration but allows parties to voluntarily proceed with their case to a medical panel to first determine liability and secondly let the parties determine the amount of damages. If the parties fail to agree on an amount in 30 days, the panel will then decide on damages (S.D. Codified Laws Ann. §§ 21-25B1 to 21-25B26).[81] However, the South Dakota State Medical Association's legal counsel says, "To my knowledge it (the law) has never been used. It requires providers to have their patients sign arbitration agreements, which has never been done. There has been some talk about implementing it, but I am not aware that any provider (doc or hospital, primarily) has done so. Initially, the arbitration panels were selected, but I doubt that any are in place now."[82]

Utah

The Prelitigation Section of the Division of Occupational and Professional Licensing, was established in accordance with Sections 12 through 16 of the Utah Health Care Malpractice Act, located in Title 78, Chapter 14, Utah Code Ann. (1953), as amended, and implemented by the Prelitigation Panel Review Rules located in Title R156, Chapter 78A, Utah Administrative Code. The Section's duties and responsibilities are to provide medical malpractice prelitigation hearing panels when properly requested by a party initiating a medical malpractice action. The Section's duties and responsibilities are part of a comprehensive scheme set forth in the Act. The purpose of the scheme is to address the soaring number of suits and claims for damages and amount of judgments and settlements arising from health care. In turn, this has caused increased insurance premiums and claims, which translates into increased health care costs, both through the health care providers passing the cost of premiums to the patient, and through the provider's practicing defensive medicine, because the provider views a patient as a potential adversary in a lawsuit. It also may have the effect of discouraging certain providers from continuing to provide services, because of the high cost and possible unavailability of malpractice insurance. The primary purpose of the program is to expedite early evaluation and settlement of malpractice claims.[83]

According to Adele Bancroft, Prelitigation Coordinator for the Utah Commerce Department, the number of cases found to be meritorious is quite small.[84]

	FY 2002	*FY 2003*	*FY 2004*	*FY 2005 (July/August)*
Prelitigation action	**392**	**549**	**484**	**73**
Cases opened	**63**	**40**	**32**	**3**
Requests denied	**324**	**288**	**499**	**149**
Hearings scheduled	**433**	**414**	**577**	**73**
Outcome of Pre-litigation cases				
No merit	**230**	**201**	**290**	**39**
Meritorious	**33**	**27**	**32**	**5**
Stipulated	**52**	**80**	**139**	**9**
Dismissed	**43**	**58**	**59**	**12**
Split decision	**67**	**38**	**40**	**6**
Jurisdiction	**8**	**10**	**16**	**2**

80 Ohio State Medical Association, www.osma.org
[81] http://legis.state.sd.us/statutes/index.aspx?FuseAction=DisplayStatute&Type=Statute&Statute=21-25B
[82] Email, Jane Phalen, South Dakota State Medical Association, jphalen@sdsma.org, 10/22/04
[83] http://www.dopl.utah.gov/programs/prelitigation/
[84] Fax, 9/22/04

It is extremely difficult to determine whether the pre-litigation process encourages litigants to either settle or drop their medical malpractice disputes without going to court. There have been too many other changes in tort laws, court rules, and health care practices to isolate the overall impact of these hearings. The Utah Legislature's staff research shows half of those who request a pre-litigation hearing either drop or settle their claims before they enter the legal system. However, they could not determine which, if any, of the state's tort reforms are responsible. Through the mid 1970s and 1980s the Utah Legislature saw the rising cost and number of medical malpractice claims threatening the availability of health care services in the state. A number of reforms were enacted to address what was termed a "medical malpractice crisis." The pre-litigation requirement enacted in 1985 was aimed at reducing the cost of resolving medical malpractice disputes by encouraging litigants to meet and discuss their claims before a pre-litigation screening panel. The panel, consisting of an attorney, a physician and a lay person, offers the litigants non-binding advice as to whether the case is "meritorious" or "non-meritorious." In recent years, there has been a debate over the effectiveness of the pre-litigation requirement in encouraging an early resolution of claims. As an alternative to new reforms, the Legislature's staff recommended a number of ways each major interest group could help improve the pre-litigation process. The Division of Occupational and Professional Licensing, which administers the pre-litigation process, should create a task force made up of the various participant groups to clarify a number of procedural issues. The Bar Association should do more to inform its members about how to comply with its code of ethics for medical malpractice. The Bar should also provide training for members who wish to handle medical malpractice litigation. The Utah Medical Association should encourage its members to show a greater willingness to settle claims ruled to be meritorious and it should also encourage qualified physicians to serve as panel members.[85]

Vermont

Vermont law requires that all medical malpractice actions be submitted to a review panel before trial. Either party may appeal the finding unless the parties agree on binding arbitration (Vt. Stat. Ann. Tit. 12 § 7002).[86] The Vermont Medical Society reports that the review panels in Title 12 are not being used, or are used very infrequently. An amendment in 1991 to make this chapter mandatory was made contingent on the enactment of a universal access health care system - an event that has not occurred.[87]

Virginia

The Virginia Medical Malpractice Act provides a system of medical malpractice review panels to assess the validity of newly-filed medical malpractice claims. At the request of either party, the Supreme Court of Virginia appoints a panel to review the claim. Va. Code Ann. § 8.01-581.12 (LEXIS 2003).[88]

According to the Supreme Court of Virginia *Judiciary's Year in Review 2002*,[89] a system of Medical Malpractice Review Panels was instituted in Virginia in late 1976. The Panel may be viewed as a blue ribbon jury or a fact-finding body of five individuals whose decision is advisory and not binding. The composition of the panel is one judge, two attorneys and two health care providers. During 2002, 31 panels were assigned, a decrease of 33 panel assignments from the previous year. Since the inception of the Medical Review System, an average of 143 panels per year have been processed. From the first panel assignment on Dec. 6, 1976 through December 31, 2002, 3,724 panels have been requested through the Supreme Court. Of this total, 1,594 have been concluded, 325 dismissed, 1,754 withdrawn and 51 remain in a pending or to-be-heard status as of the end of 2002. The 1977 General Assembly amended the original legislation setting up the Medical Malpractice Review Panel System and provided the following opinions, which a panel might determine pursuant to § 8.01-581.7 of the Code of Virginia:

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[85] Utah Legislative Service Report, July 1993, http://www.le.state.ut.us/audit/93_07dig.pdf
[86] http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=12&Chapter=215
[87] Madeleine Mongan, Vice President for Policy, Vermont Medical Society
[88] McCullough, Campbell and Lane, Summary of Medical Malpractice Law, June 2003, http://www.mcandl.com/virginia.html.
[89] http://www.courts.state.va.us/reports/2002/SECTIONa.pdf

1. Evidence does not support a conclusion that the health care provider failed to comply with the appropriate standard of care;
2. Evidence supports a conclusion that the health care provider failed to comply with the appropriate standard of care and that such failure is a proximate cause in the alleged damages;
3. Evidence supports a conclusion that the health care provider failed to comply with the appropriate standard of care and that such failure is not a proximate cause in the alleged damages; or
4. Evidence indicates that there is a material issue of fact, not requiring an expert opinion, bearing on liability for consideration by a court or jury (i.e., the case contains a material issue of fact that a court or jury can resolve without an expert opinion).

Of the 1,903 decisions* rendered through 2002, 1,415 (or 74%) favored the health care provider, 253 (or 14 %) favored the plaintiff and the remaining 235 (12%) fell within the last two opinion categories of §8.01-581.7. During 2002, the northern Virginia region (Area 2) reported the greatest number of medical malpractice claims filed followed by Hampton Roads (Area 5). As illustrated in Table 67, Hospitals, OB-GYN Physicians, General Surgeons and Internists continue to be the areas accounting for the largest number of panel requests.
**Total differs from Panels Concluded due to the fact that more than one opinion may be rendered per case.*

Display 60
Medical Malpractice Claims Against Specialities 1976-2002

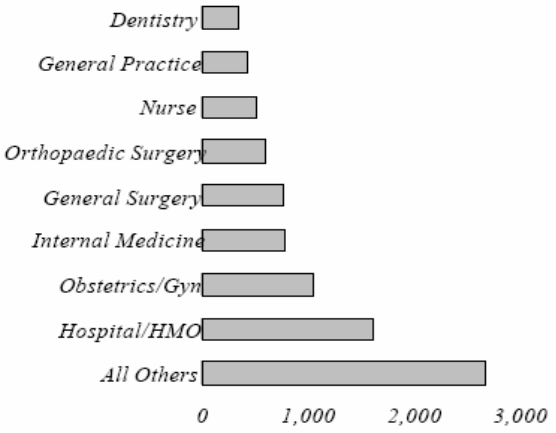


Table 67
Medical Malpractice Review Panel Statistics
July 1, 1976 - December 31, 2002

Number of Panels Withdrawn	1,754
Number of Panels Dismissed	325
Number of Panels Concluded	1,594
Number of Panels Outstanding	51
Total	3,724
Panel Decisions Pursuant to the Following:	
Section 8.01-581.7(1) (Decision for the Health Care Provider)	1,415
Section 8.01-581.7(2) (Decision for the Claimant)	253
Section 8.01-581.7(3)	123
Section 8.01-581.7(4)	112
Total	1,903

Table 68

Medical Malpractice Review Panels

Geographical Breakdown of Claims Against Specialities

July 1, 1976 - December 31, 2002

Specialities	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Total
Ambulance Service	0	-	-	1	-	1	2
Anesthesiology	49	123	14	38	56	25	305
Cardiology	-	5	-	-	1	-	6
Chiropractor	3	16	3	3	10	1	36
Clinical Psychologist	1	4	-	3	3	1	12
Clinical Social Worker	-	-	-	-	1	-	1
Colon & Rectal Surgery	1	-	-	-	-	-	1
Dentistry	17	158	5	50	97	19	346
Dermatology	10	15	4	7	5	1	42
Emergency Medicine	29	124	23	58	108	26	368
Family Practice	9	34	19	13	35	26	136
General Practice	48	118	24	75	122	54	441
General Surgery	86	179	53	137	188	134	777
Hospital - (HMO)	148	514	75	252	388	247	1,624
Internal Medicine	65	327	35	112	157	89	785
Laboratory	-	1	-	-	2	1	4
Neonatology	-	3	-	-	-	-	3
Neurology	13	53	2	13	12	7	100
Neurosurgery	9	55	7	17	43	12	143
Nurse	55	86	17	124	199	34	515
Nursing Home	14	24	2	22	32	10	104
Obstetrics & Gynecology	101	317	44	161	319	108	1,050
Ophthalmology	9	25	6	9	27	19	95
Optometrist	-	6	2	3	5	-	16
Orthopedic Surgery	78	222	25	76	134	62	597
Otorhinolaryngology	11	27	2	5	27	14	86
Pathology	5	34	-	22	21	6	88
Pediatrics	27	57	1	49	75	22	231
Pharmacist	2	8	-	10	33	16	69
Phlebotomist	-	1	-	-	1	-	2
Physical Medicine	-	1	-	9	6	1	17
Physical Therapist	1	13	-	2	3	-	19
Plastic Surgery	-	-	-	1	-	-	1
Podiatrist	8	45	4	10	43	8	118
Professional Counselor	7	70	4	17	23	10	131
Psychiatry	-	3	-	-	1	-	4
Radiology	14	58	1	36	59	18	186
Social Worker	16	171	10	37	76	40	350
Thoracic Surgery	-	1	-	2	1	-	4
Urology	1	5	-	1	6	7	20
Total	837	2,903	382	1,375	2,319	1,019	8,835

Washington

Washington law mandates mediation of medical malpractice actions that tolls the statute of limitations for one year but also allows a patient to demand a jury trial (Wash. Rev. Code Ann. §§ 7.70.100, 7.70.120).

"Prior to this legislation we already heavily promoted and used voluntary mediation pre-litigation and during litigation. Therefore, this measure changed nothing and has had no impact on losses, premiums, or frequency of claims," according to Gary Morse, General Council, Physicians Insurance. No attempt is made to measure any cost savings that result from mediation, Morse said. "We and the plaintiff attorneys just know it works. The legislation was not needed. Like so much other legislation, it was adopted so the legislators could claim they did something about the problem."[90]

Wisconsin

The Medical Mediation Panels codified in Chapter 655 of the Wisconsin Statutes were created in 1986. With limited exceptions, Chapter 655 requires all parties to a medical malpractice action to participate in the procedure described therein either prior to or immediately after the commencement of a court action. Although referred to in the statutes as "mediation," the procedure can be more accurately described as early neutral evaluation. This procedure was established in order to provide "an informal, inexpensive and expedient means for resolving disputes without litigation." Sec.

[90] gary@phyins.com, email correspondence 9/15/04 and 9/16/04

655.42(1), Stats. The system is funded by assessments against health care providers. The statutory format contains the following features:

1. The procedure is nonbinding.
2. Initiation of the procedure is mandatory (although the parties have the authority to waive further activity after a request for mediation has been filed).
3. The procedure must be completed within 90 days after the initiating document (a request for mediation) has been filed unless all parties agree to an extension.
4. The procedure is informal. No physical examinations or productions of records may be ordered, no witnesses may be subpoenaed, no oaths may be administered and no stenographic record may be made of the proceedings. Formal discovery is prohibited during the 90-day period.
5. The procedure is presided over by a panel consisting of an attorney, a health care provider and a public member.[91]

Pursuant to the Guidelines promulgated by the Administrator, the parties are required to submit written statements of the case in advance of the session. The statements explain when and by whom the patient was being treated and the nature of the treatment. Additionally, the statements discuss the propriety or impropriety of the treatment and the nature and extent of the patient's damages. Finally, the statements indicate the amount, if any, for which the parties are willing to resolve the matter at that stage of the proceedings. The parties are also required to provide copies of the relevant medical records. The statements and medical records are sent to the three-member panel in advance of the session.[92]

On the day of the session, the panel convenes one-half hour before the parties arrive and preliminarily discusses the issues presented in the statements. Upon the arrival of the parties, the claimant supplements the statement with a brief oral presentation of the case. The respondent follows with a similar presentation. The panel members often ask questions of the parties during the presentations. After the oral presentations, the panel meets with the claimant outside the presence of the respondent, followed by a meeting with the respondent outside of the presence of the claimant. During these ex parte meetings, which are designed to induce more openness and candor than might otherwise exist, the panel discusses the strengths and weaknesses of the case and ascertains the "bottom-line" settlement positions of the parties. The panel continues to shuttle between the parties until the matter is resolved or until the parties reach an impasse, at which time the session is terminated and the panel provides the parties with their objective evaluation of the case. Sessions are typically one and one-half to two hours in duration.[93]

This procedure is designed to fully resolve the less complex, relatively low damage cases. An examination of those cases in which the request for mediation is filed prior to the commencement of a court action and in which the claimant is seeking $25,000 or less indicates that the procedure appears to be accomplishing that objective. Of those cases, 24% have been settled at or shortly after and as a result of the session; 49% have not been "settled" (in terms of money changing hands) but have not subsequently been filed in circuit court and the statute of limitations has now expired; and in an additional 11% of the cases, a court action was subsequently commenced but the parties have indicated that the session nevertheless served a constructive purpose.[94]

An examination of all of the cases in which the request for mediation was filed prior to the commencement of a court action (regardless of the amount of damages at issue) reveals that 8% of those cases were resolved at or shortly after and as a result of the session; 40% were not settled but have not been filed in circuit court; and 24% were filed in court but the parties have indicated that the session nevertheless served a constructive purpose. [95]

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[91] Medical Mediation Panels, Randy Sproule, Director, 110 East Main Street, Suite 320, Madison, WI 53703-3356, Phone: (608) 266-7711, Fax: (608) 261-2352, Wisconsin Court System web site, http://www.wicourts.gov/about/organization/offices/mmp.htm.
[92] Sproule
[93] Sproule
[94] Sproule
[95] Sproule

The requests for mediation filed in conjunction with the commencement of a court action tend to involve the more complex, potentially higher damage claims. Because of the complexity of those cases and the prohibition against discovery, the defendants are usually unable to adequately evaluate the case in advance of the session. As one might expect, the procedure has been less effective for those cases: only 4% are settled at or shortly after and as a result of the session; in an additional 52% of the cases the parties were of the opinion that the session served a constructive purpose even in the absence of a settlement.[96]

The Medical Mediation Panels were created to replace the Patient Compensation Panels—a nonbinding arbitration procedure that had been in effect since 1975. Over the years, the Patient Compensation Panels procedure had become an expensive, prolonged process. The average arbitration hearing lasted 4 days; some hearings lasted two or three weeks. The hearings required testimony from expert witnesses. The current format was the result of a concerted effort by the legislature to reduce the cost and length of the procedure for resolving medical malpractice disputes. Although the current format is less expensive and more expeditious than its predecessor, those improvements have come at the expense of the finality that was received in more than 85% of the cases that proceeded through the Patient Compensation Panels. Whether that trade off is worthwhile is an issue that continues to be debated.[97]

From 1986 to 1994, in cases where the request for mediation was filed prior to the commencement of a court action:

- In 9.2 percent of the cases, settlement was a direct result of the mediation
- In 42.8 percent of the cases, there was neither a settlement nor a filing in circuit court by the time the statute of limitations had expired
- In 19.4 percent of the cases, the parties in circuit court indicated that early neutral evaluation served a constructive purpose
- In 28.6 percent of the cases, mediation was perceived as having served no constructive purpose
- From 1986 to 1995, in cases where the request for mediation was filed in conjunction with a court action:
- In 3.5 percent of the cases, settlement occurred as a direct result of the mediation
- In 41.8 percent of the cases, the parties indicated that early neutral evaluation served a constructive purpose
- In 54.7 percent of the cases, mediation was perceived as serving no constructive purpose
- In cases where the claimant sought $25,000 or less (regardless of whether the request for mediation was filed prior to, or in conjunction with, a court action), the results are as follows:
- As a direct result of mediation, in 24 percent of the cases settlement was reached at, or shortly after, the session
- In 49 percent of the cases, there was neither a settlement nor a filing in circuit court by the time the statute of limitations had expired
- In 11 percent of the cases, action was brought in circuit court, but early neutral evaluation was perceived as having served a constructive purpose
- In 16 percent of the cases, parties indicated that mediation served no constructive purpose.[98]

In cases filed between 1999 and 2001, where request for mediation is filed prior to the commencement of a court action and the claimant sought $25,000 or less:

A. Settled at or shortly after session	24%
B. Not settled, but not subsequently filed in circuit court	49%
C. Filed in circuit court after mediation but mediation served a constructive purpose	11%
D. Filed in circuit court; mediation was not constructive	16%

[96] Sproule
[97] Sproule
[98] Sproule

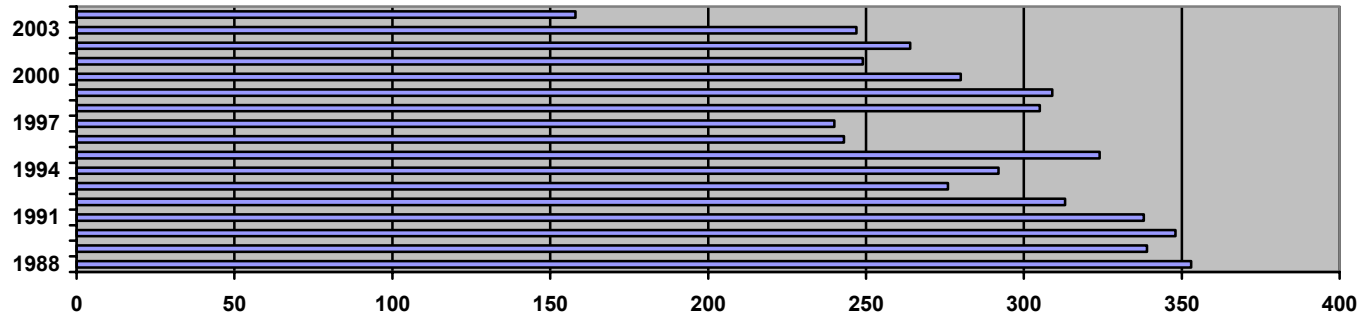
In cases filed between 1999 and 2001, in all cases where request for mediation is filed prior to the commencement of a court action:

A. Settled at or shortly after session	6%
B. Not settled, but not subsequently filed in circuit court	45%
C. Filed in circuit court but mediation was constructive	41%
D. Filed in circuit court, mediation served no purpose	8%

And in cases cases where request for mediation is filed in conjunction with the commencement of a court action (also 1999-2001):

A. Settled at or shortly after mediation	8%
B. Mediation served a constructive purpose	59%
C. Mediation did not serve a constructive purpose	33%[99]

Annual Case Filings For Medical Mediation Panels[100]



Wyoming

Wyoming does not mandate arbitration in medical malpractice actions because the Wyoming Supreme Court held mandatory arbitration unconstitutional as a violation of equal protection under Hoem v. State (Wyo. 1998).[101]

Constitutional Amendment C on the 2004 General Election Ballot if passed will allow for mandatory alternative dispute resolution or review by a medical review panel before the filing of a civil action against a healthcare provider.[102]

[99] Sproule
[100] Sproule
[101] Brian C. Schuck and Susan Martin, "Wyoming Tort Reform and the Medical Malpractice Insurance Crisis: A Second Opinion," 28 *Land and Water Law Review*, 593, 625 (1993)
[102] Wyoming Secretary of State, http://soswy.state.wy.us/election/2004/const-c.htm