Medical-Legal Screening Panels as an Alternative Approach to Medical Malpractice Claims

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A Study for The American Bar Foundation
During the 1970-71 academic year, Robert L. Winikoff, a member of the *William and Mary Law Review* Staff, prepared an extended empirical research project with the cooperation and financial assistance of The American Bar Foundation. The purpose of this study was to survey the current operational efficiency of joint medical-legal panels in handling medical malpractice claims. The present publication reflects the results of the survey.

The Documentary Supplement of the *William and Mary Law Review* is designed for special projects which do not fit the conventional format of scholarly articles or staff commentary.
MEDICAL-LEGAL SCREENING PANELS AS AN
ALTERNATIVE APPROACH TO MEDICAL
MALPRACTICE CLAIMS

Recently, the Supreme Court of Minnesota, in Anderson v. Florence, suggested that due to the numerous problems engendered by medical malpractice litigation, the establishment of a professional medical-legal review board would provide a more competent forum for the initial trial of such controversies. While this proposal has at least superficial appeal, the medical and legal communities have found themselves without sufficient factual and statistical data to evaluate properly its feasibility. It is clear that empirical research is necessary to isolate present problems and to suggest appropriate changes acceptable to both professions.

With the above situation in mind, this study was undertaken in order to discover and analyze the substantive and procedural problems involved in the litigation of medical malpractice suits, and to determine whether these problems would be alleviated by the creation of medical-legal review panels. Among the problems which will be treated are: the resources available to both sides to prepare a case for trial; the competency of the traditional jury trial method for establishing liability in this very technical area; and the effect of malpractice suits on the cost of medical treatment, liability insurance, and the standard of medical care. Questions concerning the tardy compensation of aggrieved plaintiffs, the much discussed “conspiracy of silence” among physicians, and the goals and motives of the medical profession with regard to malpractice will also be discussed.

It should be remembered, however, that the predominant theme of this study is the determination of which procedures provide the greatest possibility of a fair and equitable result for both the patient and the

1. 181 N.W.2d 873 (Minn. 1970).
physician. It should also be noted at the outset that, although the empirical research plan for studying the success of existing medical-legal screening panels was carefully devised, the fact that on many questions the study failed to provide results which were capable of statistical analysis is itself illustrative of many of the problems surrounding the area of medical malpractice litigation.

**Why More Medical Malpractice Suits?**

We wanted to know what was behind the apparent rise in the number of [medical malpractice] law suits. Was malpractice litigation an indication of the quality of medical care? Could the malpractice situation shed light on other health care problems?

Our preliminary research revealed a surprising lack of information. There were few statistics. There was no basic literature in the field.2

The Department of Health, Education, and Welfare estimates that 10,000 medical malpractice suits are filed each year, but HEW notes that this figure is based substantially on conjecture and is not entirely reliable. In testifying before the Senate subcommittee investigating medical malpractice, one Cleveland defense attorney estimated that the number of medical malpractice suits he has been involved with increased 400 percent between 1955 and 1966.3 Even this figure may now be outdated. Testifying before the same subcommittee, a representative of Aetna Life and Casualty Ins. Co. stated that the number of claims increased 43 percent between 1965 and 1969, and the average cost per claim increased 200 percent.4

The American Medical Association, in a 1963 survey, determined that 53,000 physicians, one out of six nationally, have been subjects of malpractice claims.5 The figure is undoubtedly higher now. The Nettleship Company of Los Angeles testified that it incurred one claim for every 20 doctors insured during 1957. By 1969, the same company handled one claim for every ten doctors, or 1,100 claims for 11,000 doctors then insured.6

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3. Id. at 8.
4. Id.
5. Id.
6. Id.
Many explanations for the increase in malpractice litigation have been advanced. Some physicians believe that the lawyer's contingent fee basis of accepting cases is the primary reason. Some attorneys feel that the increase in litigation is due to inferior medical practice of many physicians. Both charges are probably unfair.

A study undertaken by the California Medical Association in 1958 indicated that only ten percent of the malpractice claims were brought on the initiative of the claimant's attorney. The study suggested that nearly 65 percent were initiated by the claimant, and an additional 25 percent were commenced on the advice of family or friends.  

The Senate subcommittee studying medical malpractice concluded that the following were among the causes for the increase in the number of suits and claims:

1. The majority of malpractice claims arise from injuries allegedly sustained during treatment or surgery. Therefore, certain physicians, because of their specialties, have a greater exposure to malpractice suits than others. This growing group of physicians includes orthopedic surgeons, neurosurgeons, anesthesiologists, obstetricians, and gynecologists.

2. There is a growing national trend toward court actions for grievances that once were not generally the subjects of court actions.

Insurance companies reported to the subcommittee that in suburban areas, malpractice suits tend to increase in some direct proportion to the population growth. It is explained that the mobility of the American people, living in new neighborhoods, inhibits the growth of community traditions and trust in physicians.

3. The public image of today's doctor is not what it was in the past. Today's poor image may be due, in part, to the high fees charged by physicians. The medical profession itself has helped to foster the negative image. Crawford Morris, testifying before the subcommittee, reported:

   It is common knowledge today that almost all doctors are making enormous amounts of money, refuse to make house calls, play golf on Wednesdays, drive expensive cars, own yachts, hunting lodges and apartment houses.

7. Id. at 16.
8. Id. at 2.
9. Id. at 2-3.
The doctor’s image is sadly tarnished. Once thought of as “the old country doctor driving through the rain all night to sit beside a sick patient”, they are now thought of as “supersuccessful businessmen.” This, perhaps subconscious, attitude makes patients more willing to sue their doctors and makes patients on juries more willing to return a verdict, and one of considerable size, against doctors.10

4. It is also suggested that a breakdown of rapport between physician and patient often leads to litigation. The American Medical Association told the subcommittee:

The growing complexity of life and the increased volume of medical care rendered has tended to break down the physician-patient rapport which once was much in evidence. In former days, the family doctor was more likely to be a family friend. Most patients wouldn’t think of suing a family friend. Today the doctor is too busy to have many family friends and medical practice has unavoidably become impersonal.11

This breakdown is due in part to the growing specialization in medicine.

Instead of a family physician, the patient may have a string of specialists whom he calls on when needed. These are more apt to seem like impersonal businessmen to the patient than like a family friend.12

5 The increased medical load carried by physicians is a definite factor in the rise of malpractice litigation. Physicians have less time to spend with each patient. Many are overworked. Consequently, their potential for error increases. Furthermore, some patients may feel ignored under such conditions.13

Medicare, medicaid, and the increased coverage of medical and hospital insurance has produced a skyrocketing rise in effective demand for medical services.

Since the supply of physicians could not be increased propor-
tionately, the demand could be met only by the existing number of physicians providing more units of patient care. Higher volume of patient care inevitably produces a higher exposure of legal risks and a higher volume of suits.  

6. Other factors contributing to the increase in medical malpractice litigation are the publicity given to higher malpractice judgments and settlements, and exposure through the mass media, particularly television, of stories concerned with medical malpractice.

The Traditional Procedure

Eighty-five percent of medical malpractice suits allege negligence, and the trial procedure of malpractice cases is typical of any negligence action.

In preparing the case for trial, plaintiff's attorney or his expert witnesses will examine the plaintiff's person and will review all relevant hospital or physicians' records. A complaint is then filed and is usually answered by the physician with the aid of his insurance carrier.

In trial, the plaintiff and defendant offer evidence, a substantial portion of which customarily takes the form of expert testimony by other physicians, and the verdict is returned by the jury—provided that the plaintiff has offered sufficient evidence to get to the jury. The two main issues which must always be resolved in malpractice cases are:

(1) Was there professional negligence on the part of the physician? and
(2) Was this negligence the proximate cause of plaintiff's injuries?

Aside from the particular problems either side may face in preparing or presenting a case, one basic question must be asked: Is the traditional trial approach to negligence actions a competent procedure by which to handle medical malpractice cases? This question depends upon whether a judge or jury is competent to decide the two aforementioned issues—was there negligence, and did injury result therefrom?

In other types of negligence litigation, the trier of fact is called upon to make decisions based upon conflicting evidence. In medical malpractice cases, the trier of fact is called upon to decide what inferences can be drawn from the often conflicting expert medical testimony concerning the issue of whether a certain type of medical procedure was haphazardly administered or was professionally incorrect. The trier of fact is also called upon to decide whether a certain medical

14. Id.
15. Id. at 1.
16. Id. at 5.
procedure was the cause of the patient's injury or whether the injury was caused by something else. These are questions which often can be answered only by a panel of specialists in the area of medicine concerned. Therefore, there exists the very real question of whether both patient and physician can obtain justice within the traditional trial system.

**The Patient's Point of View**

The patient faces four major problems in his attempt to secure a favorable verdict against the physician in a medical malpractice action: (1) preparing the case for trial; (2) obtaining competent expert witnesses; (3) overcoming, especially in less urban areas, the image of the physician in the community; and (4) financial capacity to endure prolonged litigation and delay in obtaining compensation for the injury.

The first two problems involve the difficulty of obtaining expert advice and testimony concerning the injury. The patient's need for an expert does not begin and end with the presentation of his case to the jury. He must, in order competently to prepare for and evaluate his case, have medical advice before trial.

Ideally, medical counsel should be available to the patient before the filing of a suit. If a patient has suffered a bad result from medical treatment and feels that some recourse should be available against the physician or hospital involved, he consults his attorney. When the attorney attempts to investigate the case and make a determination as to whether the patient has a potentially successful claim against the physician, he first meets with that state of non-cooperation on the part of the medical profession referred to as "the conspiracy of silence."

The patient's attorney needs the medical or hospital records of his client, and he needs one or more physicians to read these records, examine the patient, and render his professional opinion as to whether the cause of the injury was professional negligence. But in most cases and in most areas, the attorney experiences difficulty in securing such expert advice. A New York lawyer who specializes in medical malpractice litigation has said that physicians often will not even discuss the possibility of helping him determine the validity of a negligence case against another physician. He has further stated that in some specialties, particularly ophthalmology and pediatrics, he will not even accept a case because he knows that he can get no specialists in these fields even-to
talk to him, much less to help in the preparation of the case or testify in court.\textsuperscript{17}

Additionally, hospitals and physicians are loath to part with the medical records of a patient and therefore it is often necessary first to file suit and then subpoena the records. Thus the attorney may be forced to bring a suit before he has the information necessary to determine properly whether an action in fact lies against the defendant physician.

Some physicians maintain that plaintiffs no longer experience great difficulty securing expert testimony. They point to the fact that cases do go to trial and that there are physicians available who will and do testify. Plaintiffs' attorneys, however, have a substantially different view. While acknowledging that there are a few physicians who will testify, they contend that these physicians suffer several major handicaps which reduce their effectiveness. First and foremost, the plaintiff often is forced to rely upon an expert witness whose specialty is outside the area of medicine involved. His impact on the jury is thereby reduced. His credentials are often less than impressive. There is also great difficulty in securing another physician in the community to testify against his colleague and thus the introduction of a "foreign" doctor further reduces the expert's impact with the jury.

On the other hand, the defendant physician has his entire medical society plus other "name" experts to choose from in arranging his parade of expert witnesses. Where the patient's expert may quote a treatise on the subject, the physician's expert may well have written it. It is the physician who is most likely to win the battle of the experts.

In rural areas and in areas where the population tends to remain stable, the patient often is faced with the burden of overcoming the positive community image of physicians in general and the defendant in particular. This may be compounded when the patient is forced to bring in "outsiders" to testify in his behalf.

Should the patient be successful in overcoming these problems, he faces the additional burden of financial survival during the period of trial. This is especially true if the injury suffered is totally or partially disabling. From the filing of the suit to the satisfaction of judgment, there is at least a span of two years, an average of four or five, and in some cases six or more. Where the injury substantially impairs the ability of the plaintiff to earn a living, and no outside source of income

\textsuperscript{17} Interview with Albert Averbach, Plaintiff's Attorney, in Seneca Falls, New York, Aug. 24, 1971.
is available, the injured party is forced to live on his savings as long as they last, and finally on funds from government assistance programs. He may go bankrupt before settlement of his claim. Because of these financial strictures, many plaintiffs are forced to accept smaller settlements. The inequities of the jury system are obvious—those who can afford to wait frequently recover handsome judgments; those who cannot afford such a long wait invariably must accept small settlements.

The Physician's Point of View

The physician's reluctance to testify can be most simply explained as professional pride that manifests itself in an unwillingness to condemn fellow physicians. While this may be true to some extent, the physician is not different from the lawyer or scientist or any other professional man who is occasionally called upon to testify against a member of his profession. The primary motives of the physician in refusing to testify probably have little to do with protecting his fellow physician. In most cases, the offending physician will be censured at peer review meetings; his hospital staff privileges may be suspended, or if the offense is serious enough he may be forced to leave the hospital staff or even the community.

A far more substantial motive is probably that of fear. Today's doctor is convinced, justifiably or not, that malpractice claims are increasing at an alarming rate, and that publicity of a claim, valid or groundless, leads to runation of reputation, destruction of practice, and actually promotes future claims by suggestion. Physicians fear that every bad result, whether due to negligence, to the inherent risk of a medical procedure, or to some unrelated cause, will become the subject of a malpractice action. "There, but for the grace of God, go I," explained one physician, meaning that not all medical treatment is successful and that he or any other doctor could find himself defending a malpractice claim.

The medical profession is also concerned with the high cost of medical malpractice liability insurance and the effect that a successful malpractice suit against a physician in a particular region will have on local insurance rates. In some areas, insurance rates are rising on an average of 40 to 60 percent per year. In other areas, 100 percent annual increases are common. Additionally, the amounts of recoveries and settlements have become so high that the safe coverage for physicians has risen from $100,000 minimum coverage to $1,000,000.

Adequate insurance coverage for an orthopedic surgeon in New
York might have cost $1,500 per year ten years ago. It might now cost him $15,000. The effects of high insurance rates are felt particularly by the young physician who does not yet have a lucrative practice and cannot afford the expense, and by the older practitioner who carries only a limited workload and whose practice may not be sufficient to support the high cost of insurance and other expenses.

In addition, insurance companies may bring pressure on any physician who is considering testifying for the plaintiff in a malpractice action. Such pressure might increase the physician’s fear of cancellation of his insurance or of his right to renew his own policy. This is a particularly realistic fear in view of the trend toward withdrawal from the field of medical malpractice liability insurance by many insurance companies. Consequently, malpractice insurance is becoming more difficult to obtain.

The insurance companies offering medical malpractice insurance report that they have not shown a profit from this type of insurance, and in fact have reported losses in every year since 1959. Many are terminating this type of coverage. Physicians are reluctant to jeopardize their chances of obtaining liability insurance, and in view of the decreasing availability of this insurance, this attitude is readily understandable.

THE PUBLIC’S POINT OF VIEW

We are all patients in the final analysis, and the effects of medical malpractice litigation on medical costs and care concern all of us. These effects are summarized by the Senate subcommittee report on medical malpractice as follows:

4. Already, higher judgments and settlements are having the following direct results:

   (a) Companies providing malpractice insurance are increasing the cost of coverage.
   (b) These costs—in the form of higher premiums—are being passed on to patients, their health care insurance companies, and Federal health care programs.

5. The rising number of malpractice suits is forcing physicians to practice what they call defensive medicine, viewing each patient as a potential malpractice claimant. Physicians often order excessive diagnostic procedures for patients, thereby increasing the
cost of care. Moreover, they are declining to perform other procedures, which in themselves, may entail some risk of patient injury

At present, it appears that no one affected by the rise in malpractice suits and claims has been able to deal with this problem in a manner that promises to alleviate this situation.18

The subcommittee concluded further that the greatest share of the cost to the insurance companies for malpractice suits and claims is paid to the legal community, thus confirming the complaints of many physicians. The report continued:

[a] major factor in the costs of such suits revolves around the adversary proceeding of the plaintiff attorney building his case and the defense attorney and insurance company building their case.

The preliminary investigation necessary to file a suit, and the subsequent expense of building a defense add substantially to the cost of malpractice litigation.

One insurance company told the subcommittee that of the total lost costs from its malpractice business, only 30 percent of these funds actually go to the patient; 15 percent goes to the plaintiff’s attorney; and 55 percent is taken by defense attorney fees and defense investigation costs.

Another said that 38 percent of each claim’s loss goes to the patient; 35 percent goes to the plaintiff’s attorney; and 27 percent is taken by defense attorney fees and defensive investigation costs.

One proposal [for limiting the legal expense] calls for a screening panel composed of a joint state bar and medical association committee.19

MEDICAL-LEGAL SCREENING PANELS

As noted above, medical-legal screening panels have been suggested as a possible alternative procedure to jury trials in malpractice cases. There are about 20 panels currently in operation, and more are under consideration by state legislatures, and medical and bar associations.

Most screening panels have been organized through the cooperative efforts of state or county bar and medical societies. Others have been

19. Id. at 10.
created by state court rules. The authority of the screening panel may be state-wide or it may be restricted to a particular county or counties. The panels are composed of equal numbers of doctors and lawyers who are selected for membership by the county or state bar and medical societies. Membership on the panel ranges from 6 to 20 persons. Some panels have provisions for permanent membership, some for terms of years, and others provide for two chairmen, one from the medical profession and one from the legal profession, with the balance of the panel chosen on a case-to-case basis. Most of the panels additionally provide for the selection of an expert or specialist when the nature of a particular case warrants.

The goals and motives of malpractice screening panels are twofold: To prevent, where possible, the filing in court of actions against physicians and their employees for professional malpractice in situations where the facts do not warrant a reasonable inference of malpractice; and to make possible the fair and equitable disposition of legitimate claims against physicians.

The panels recognize that the medical profession fears the mere filing of a malpractice action in court because of the belief that a court claim, even though ill-founded, causes substantial harm to the reputation and practice of the physician involved. The panels further recognize that persons having legitimate grievances against physicians often encounter the greatest difficulty in obtaining expert testimony with which to substantiate their claims in court. The panels therefore provide expert witnesses to a plaintiff if, after consideration of the case, the panel decides that professional negligence might reasonably have been the cause of the injury and the physician or his insurance company and the claimant have been unable to agree on an out-of-court settlement.

An additional goal of the panels is to expedite the disposition of cases, thereby sparing the parties the added burden of time, expense, and emotional fatigue usually associated with prolonged litigation.

Typically, medical-legal screening panels are not arbitration boards. Though binding arbitration procedures have been proposed and debated, the panels currently in operation have no power to bind the parties by their findings. The exception is New Jersey, where under Supreme Court Rule 4:21, the parties may agree that the decision of the panel will be binding.\textsuperscript{20}

Additionally, submission of a case to the panel is on a voluntary

basis, and either party may choose to by-pass the panel and settle the claim by court action or settlement negotiations. Furthermore, the panels make no determination of damages. Their sole function is to determine the reasonableness of the claim of professional negligence. Typically, the panel will answer two questions: (1) Is there any substantial evidence of malpractice? (2) Do the facts tend to show to a reasonable medical probability that the claimant was injured by the negligent act?

The procedures for submitting a case to a panel, and for review of the case by a panel, are basically similar for all panels currently in operation. The procedure used by the Pima County, Arizona plan, one of the earliest and most successful screening panels, is presented as typical of panel procedure.

**The Pima Plan**

III. CASES SUBMITTED. Any attorney may submit a case for the consideration of the Panel by addressing a request, in writing, signed by both himself and his client, to the Chairman of the Medicolegal Committee of the Bar Association. This letter request shall contain the following:

1. A brief statement of the facts of the case, showing the persons involved, the dates, and the circumstances, so far as they are known, of the alleged act or acts of malpractice.

2. A statement authorizing the Panel, through its Chairman, to obtain access to all medical and hospital records and information pertaining to the incident and, for the purposes of its consideration of the matter only, waiving his client's privilege as to the contents of those records. Nothing in that statement shall in any way be construed as waiving that privilege for any other purpose or in any other context, in or out of court.

3. An agreement that the deliberations and discussions of the Panel and of any member of the Panel in its deliberation of the case will be confidential within the Panel and privileged as to any other person, and that no Panel member will be asked in any action to testify concerning the deliberations, discussion and internal proceedings of the Panel.

4. A request that the Panel consider the merits of the claim and render its report to him.

5. A statement that the attorney has read, understands and subscribes
to the plan for screening medical malpractice cases and has advised his client thereof and that the client agrees to the submission of the facts pursuant to the plan.

Cases which the Panel will consider shall include all cases involving any alleged act of professional negligence occurring in Pima County, Arizona, by a member of the Society, his servants, agents, or employees.

IV. PROCEDURE BEFORE THE PANEL. Requests for review submitted to the Chairman of the Medicolegal Committee of the Bar Association shall be brought before the next regularly scheduled monthly meeting of the Joint Medicolegal Committee of the Medical Society and Bar Association. At that time the Joint Committee, sitting as the permanent members of the Panel, shall determine what, if any, additional physicians or attorneys shall be called to sit in review of each case, and a date and time shall be set for the Panel's hearing of and consultation on each case. In no instance shall the date assigned be more than 45 days after the receipt by the Chairman of the Medicolegal Committee of the Bar Association of the request for review. In any hearing of any case brought before the Panel for review a quorum of the Panel for the purpose of deciding the issues submitted to it, shall consist of a majority of those permanent members of the Panel who have sat on all hearings of the issues.

At the time set for hearing of the case the attorney submitting it for review shall be present and shall state his case, including a resume of the facts constituting alleged professional negligence which he is prepared to prove. The physician or physicians against whom the claim is brought may be present and may make a statement of his or their case. The monetary damages in any case, if there are any, shall not be subject of inquiry or discussion. The hearing will take the form of an informal discussion, and no official record shall be kept. When the parties present have been heard the Panel may take the case under advisement or it may request that additional facts, records or other information be obtained and presented to it at a supplemental hearing, which shall be set for a date and time certain, not longer than 15 days from the date of the original hearing unless the attorney bringing the matter for review shall in writing consent to a longer period. Any second hearing shall be held in the same manner as the original hearing, and the attorney and physician concerned may be present.

Each case shall be taken under advisement by the Panel, which shall consider all of the relevant material made available to it at the hearings
or otherwise, in the form of statements or records. The Panel shall consider only whether, in the light of the material presented, there is a reasonable possibility that the acts complained of constitute professional negligence, and whether there is a reasonable medical probability that the claimant was injured thereby. The Panel shall make no effort to resolve disputed questions of fact except to determine whether in its judgment there is any substantial evidence to support the facts alleged by the claimant. The Panel shall make no findings respecting the quantum of damages in the case, if there are any.

The Panel shall not make any effort to settle or compromise any claim, or express any opinion on the monetary value of any claim. All votes of the Panel on any such question before it will be by secret ballot. All decisions shall be taken by a majority vote of those permanent members of the Panel present who have sat on all hearings of the issue.

Its answers to these questions shall be submitted in writing, to the attorney bringing the matter for review, and, if he or his representative has appeared before it, the physician concerned. A copy of each report shall be retained in the permanent files of the Panel. The deliberations of the Panel shall be and remain a secret. The written opinion shall in every case be signed for the Panel by its elected Chairman, and shall contain only the conclusions reached by a majority of its members, except that any Panel member may request in writing that his dissent from the conclusions of the Panel be noted in the official records of the Panel, and may, at his election, append to the written report submitted to the parties concerned his own written dissenting opinion. The opinion reached in any case shall be treated in every respect as confidential between the Panel and its members on the one hand and the persons directly concerned in the case on the other.

In any case where the Panel has determined that the acts complained of were or reasonably might be professional negligence and that the claimant was or reasonably may have been injured thereby, the Panel, its members and the Medical Society will cooperate fully with the claimant in retaining a physician or physicians qualified in the field of medicine involved, who will consult with and testify on behalf of the claimant, upon his payment of a reasonable fee, to the same effect as if the said physician or physicians had been employed originally by the claimant. In a case where the Panel has determined that there is no reasonable possibility that the acts complained of constituted professional negligence and/or no reasonable medical probability that the
claimant was injured thereby, the attorney bringing the matter for
review shall thereafter refrain from filing any court action based upon
it unless personally satisfied that strong and overriding reasons compel
such action to be taken in the interest of his client, and that it is not
done to harass or gain unfair advantage in negotiation for settlement.
It is not intended that the submission of any case to the Panel shall be
considered as a waiver by the attorney or his client of their ultimate
right to decide for themselves whether the case shall be filed. However,
any attorney who brings a case before the Panel shall weigh its
conclusions in the greatest professional good faith.  

THE EMPIRICAL STUDY

The Problem

An empirical study was designed for the purpose of evaluating the
effectiveness of the medical-legal screening panel as an alternative pro-
cedure for medical malpractice claims. The primary goal of the study
was to determine whether the screening panels could alleviate many of
the disadvantages faced by physicians and patients in the traditional trial
procedure and still provide a forum in which both parties would re-
ceive fair and just treatment.

The major disadvantages of the traditional trial procedure were de-
termined to be:

1. The long delay between the filing of suit and final disposition, caus-
ing long delays in the compensation of valid claims;
2. The difficulty encountered by the patient in obtaining medical ex-
   perts to help in preparing the case and testifying in court;
3. The filing of unjustified or nuisance suits against the physician which
   are potentially damaging to his community reputation and practice;
4. The high cost to both patient and physician of preparing their cases
   for trial. This high cost accounts in part for the increased rates for
   malpractice insurance. This cost is ultimately passed on to and borne
   by the public. A more remote result is the creation of a reluctance on
   the part of physicians to use dynamic or innovative procedures where
   warranted by a patient’s condition because of the risks involved and the
   fear that a malpractice suit may result if the treatment is unsuccessful.

21. PIMA COUNTY, ARIZ.; JOINT MEDICOLEGAL PLAN FOR SCREENING MEDICAL MAL-
    PRACTICE CASES (1957).
Concomitant with this “defensive medicine” is the tendency of doctors to require copious diagnostic tests, at great cost to the patient. It is apparent that these tests are prescribed in order to insure against the possibility of future malpractice claims.

Finally, because of the complex nature of most medical malpractice cases and the degree of specialized education and sophistication necessary to make competent findings of fact, the primary shortcoming of the traditional trial procedure may be that a judge or jury is simply incompetent to decide whether a physician is or is not guilty of professional negligence.

**Hypothesis**

The medical-legal screening panel is intended to provide a workable alternative to traditional trial procedures in that it should significantly reduce the number of medical malpractice cases filed in the court and should assure the patient of expert medical testimony if his claim is judged by the panel to be reasonable. The screening panels also should reduce the cost of medical malpractice liability insurance because they are conceived to screen out effectively baseless nuisance claims which might otherwise have been litigated at great expense to the insurance companies. Additionally, the screening panels should reduce costs to the insurance companies by expediting settlement of claims at the pre-litigation stage.

In summation, the medical-legal screening panels, due to their expertise, should be able to determine accurately the presence or absence of negligence. The panels also are designed to encourage seasonable settlement of just claims, thereby providing prompt compensation to aggrieved patients, and they may ultimately have a stabilizing effect on this factor in the cost of medical care.

**Questions Presented**

The following questions must be answered in order to determine the efficacy of medical-legal panels:

1. To what extent do medical-legal screening panels reduce the number of medical malpractice cases filed in the courts?

2. To what extent have the medical-legal screening panels stabilized or reduced the cost of liability insurance, and to what extent has this insurance become more accessible?
3. To what extent do the medical-legal screening panels increase the number of voluntary settlements of claims?

4. To what extent do the medical-legal screening panels guarantee and actually provide expert medical testimony to a patient who is adjudged to have a reasonable claim?

5. To what extent are the parties bound by an adverse decision of the panel, and what liabilities are incurred by refusal to submit a case to a panel or by ignoring a panel decision?

**Data Sources and Methods of Collection**

Initially, it was necessary to determine the number of screening panels presently in operation, and their locations. Questionnaires were sent to the bar associations and medical societies of the 50 states, to the highest courts of the 50 states, to the American Bar Association, and to the American Medical Association. Basically, three questions were asked:

1. Is there a medical-legal screening procedure in your state?
2. If so, under what authority was the panel formed?
3. Which insurance companies offer medical malpractice liability insurance in your state?

From the responses to these questionnaires, a list of operating screening panels was compiled. Questionnaires then were sent to the screening panels. The information requested in these questionnaires included data concerning the history of the formation of the panel, the procedures utilized by the panel, the number of cases decided by the panels yearly, and the dispositions of such cases.

When the replies were returned, five panels were chosen for additional study and personal interviews were conducted with members of each of the panels, usually including the chairman or a co-chairman.

The specific information solicited from the panels to be studied intensively was as follows:

1. The procedure, authorization, and composition of the panel.
2. Insurance rate schedules for each year of the panel’s operation.
3. Insurance rate schedules for each of the five years preceding the panel’s creation.
4. The extent to which insurance companies have cooperated in encouraging or allowing claims to be presented to the panels.

5. The number of cases submitted to the panels yearly.

6. The number of cases which are withheld from the panels on a yearly basis.

7. The number of cases which are settled without resort to the panel or the courts.

8. The number of cases which were filed in the courts during each of the five years preceding the creation of the panel.

9. The dispositions of the cases submitted to the panel, including:

   A. The number resolved in the claimant's favor.
      1) Of these, the number that were later settled without court action.
      2) The number that proceeded to trial and their disposition.

   B. The number resolved in favor of the physician-defendant.
      1) Of these, the number that were voluntarily terminated.
      2) The number that proceeded to trial and their disposition.

The opinions of the members of the panel were solicited concerning:

1. The effect of the panel on the size and frequency of settlements, or on the size of judgments;

2. The effect of the panel on the attitude of the judiciary concerning malpractice litigation;

3. The major advantages, as seen by the panel members, of the screening panel over the traditional trial approach;

4. An evaluation by the panel members of the success or failure of the panel to attain its stated goals, and their opinion on the question of whether the screening panel offers a viable alternative to the traditional jury trial approach.

Similar questions were presented to such experts in the field of medical malpractice litigation as representatives of the College of Legal Medicine, the major insurance companies offering medical malpractice liability insurance, and various attorneys who specialize in malpractice litigation.
**Results**

The results of the inquiries are presented in the following tabular compilations.

**MEDICAL-LEGAL SCREENING PANELS**

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<thead>
<tr>
<th>Panels</th>
<th>Organization</th>
<th>Jurisdiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maricopa Co., Ariz.</td>
<td>med-bar</td>
<td>county</td>
</tr>
<tr>
<td>Pima Co., Ariz.</td>
<td>med-bar</td>
<td>county</td>
</tr>
<tr>
<td>Colorado</td>
<td>med-bar</td>
<td>state</td>
</tr>
<tr>
<td>Delaware</td>
<td>med-bar</td>
<td>state</td>
</tr>
<tr>
<td>Hillsboro Co., Fla.</td>
<td>med-bar</td>
<td>county</td>
</tr>
<tr>
<td>Idaho, 4th &amp; 11th Dist.</td>
<td>med-bar</td>
<td>county</td>
</tr>
<tr>
<td>Scott Co., Iowa</td>
<td>med-bar</td>
<td>county</td>
</tr>
<tr>
<td>Maine</td>
<td>med-bar</td>
<td>state</td>
</tr>
<tr>
<td>Montana</td>
<td>med-bar</td>
<td>state</td>
</tr>
<tr>
<td>Washoe Co., Nev</td>
<td>med-bar</td>
<td>county*</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>med-bar</td>
<td>state</td>
</tr>
<tr>
<td>New Jersey</td>
<td>S. Ct. Rule</td>
<td>state</td>
</tr>
<tr>
<td>New Mexico</td>
<td>med-bar</td>
<td>state</td>
</tr>
<tr>
<td>Nassau Co., N. Y</td>
<td>med-bar</td>
<td>county</td>
</tr>
<tr>
<td>Berks Co., Pa.</td>
<td>med-bar</td>
<td>county</td>
</tr>
<tr>
<td>Phila., Pa.</td>
<td>med-bar</td>
<td>county</td>
</tr>
<tr>
<td>Virginia</td>
<td>med-bar</td>
<td>state</td>
</tr>
<tr>
<td>Seattle, Wash.</td>
<td>med-bar</td>
<td>county</td>
</tr>
<tr>
<td>Spokane, Wash.</td>
<td>med-bar</td>
<td>county</td>
</tr>
<tr>
<td>Milwaukee, Wisc.</td>
<td>med-bar</td>
<td>county</td>
</tr>
</tbody>
</table>

*Expanding procedure to entire state of Nevada.

All panels used a procedure similar to that of Pima County Arizona which was previously outlined. Membership on the panels is divided equally between physicians and attorneys.

The results disclosed that there are at least 20 medical-legal screening panels currently in operation, and it is probable that others are in operation. Furthermore, two panels are currently in the planning stage and should begin operations in the near future. One panel is being organized in Alaska, by Supreme Court rule, and another in Connecticut, by the
cooperative effort of the state bar and state medical association. Both panels will have state-wide jurisdiction.

In replying to a questionnaire concerning this study, attorney Lee S. Goldsmith of the American College of Legal Medicine wrote:

You have set yourself a formidable task in your attempt to obtain statistical information regarding medical malpractice litigation. In a recent report for the College an attempt was made to determine similar information and it was determined to be practically impossible to do so. Few states delineate in their court calendars the nature of the particular type of claim, such as professional or negligence, or delineate it to be malpractice. State [medical] societies generally do not keep this type of information, and the main sources of information, which should come from insurance companies, were generally reluctant to release such information.22

Regardless of the above-mentioned problems inherent in the survey of medical-legal panels, sufficient information was accumulated to indicate the success of the panels in reducing the number of court cases and to support at least preliminary conclusions about the overall feasibility of the panels as an alternative to the jury method of adjudicating malpractice claims.

The Number of Malpractice Cases Filed in the Courts

<table>
<thead>
<tr>
<th>Substantially Reduced</th>
<th>Little or No Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berks Co.</td>
<td>Philadelphia</td>
</tr>
<tr>
<td>Pima Co.</td>
<td>Hillsboro Co.</td>
</tr>
<tr>
<td>Washoe Co.</td>
<td>Milwaukee</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Maine</td>
</tr>
<tr>
<td>Delaware</td>
<td>Seattle</td>
</tr>
<tr>
<td></td>
<td>New Jersey</td>
</tr>
</tbody>
</table>

* Data not available for panels not listed.

Statistics were unavailable as to the total number of malpractice cases filed in the courts within the jurisdictions of the panels listed, thereby preventing "before and after" comparisons. Therefore, the above determinations were based upon the percentage of malpractice cases heard

by the panels, the percentage which by-passed the panels and were filed directly in the courts, and the percentage of cases continuing on to trial after a hearing by the panels.

The following statistical comparison of four panels is offered as an illustration of the success experienced by some, and the relative lack of success experienced by others.

**Pima Co. and New Mexico-New Jersey and Philadelphia**

<table>
<thead>
<tr>
<th>Number of Cases</th>
<th>Pima</th>
<th>N.M.</th>
<th>N.J</th>
<th>Phila.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decided by Panel</td>
<td>62</td>
<td>97</td>
<td>91</td>
<td>21</td>
</tr>
<tr>
<td>By-Passed Panel</td>
<td>0</td>
<td>18</td>
<td>218</td>
<td>250</td>
</tr>
<tr>
<td>Total-No Court Action</td>
<td>59</td>
<td>88</td>
<td>91</td>
<td>14</td>
</tr>
<tr>
<td>Total-Court Action</td>
<td>3</td>
<td>27</td>
<td>218</td>
<td>257</td>
</tr>
</tbody>
</table>

The panels that successfully reduced the number of cases filed in the courts attribute their success to the fact that they have experienced close cooperation between members of the bar and members of the medical profession with regard to malpractice actions. They reported a noticeable attempt by members of both professions to encourage the submission of claims to the panels and indicated that both professions were satisfied with the manner in which the cases were handled. Another factor not to be overlooked is that the more successful panels have not met with resistance by insurance carriers.

The less successful panels have suffered a lack of cooperation between attorneys and physicians and their corresponding failure to encourage submission of claims to the panels. In Hillsboro County, Florida, a substantial number of both professions were unaware that a panel procedure existed. This type of failure of communication is fatal to the screening panel.

Insurance companies also play a dominant role in the success or failure of a panel in reducing the number of court actions. M. W McManus, Executive Director of the Medical Society of Milwaukee, wrote:

> Since the time it was officially announced, five cases were referred for consideration. In every instance the physician declined to participate on the advice of his professional liability carrier. The mechanism has not yet been tested even though it has been available for approximately 1½ years.\(^{23}\)

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Several insurance companies offering medical liability insurance view the medical-legal screening panels with alarm. They feel that the procedure is heavily weighted in favor of the claimant, the insurance company is pressured to settle the suit due to the fact that the claimant is assured expert medical testimony. They also contend that should the claimant fail before the panel, the knowledge he has gained by virtue of the panel hearing may prove to be of sufficient benefit in a subsequent trial to more than offset the adverse effect of a negative panel vote. Therefore, the insurance companies would prefer that the decision of the panel be binding, or at least be admissible as evidence in any subsequent litigation. However, the insurance companies admit that their major concern is not the public welfare, but rather the protection of the medical profession and the insurance companies which offer malpractice policies. As one company admitted:

In this commentary the Company has not considered the possible effect of the [screening panel] plan on the public or the legal profession. Our sole concern is the effect of the plan on the medical profession.

If the Medical Protective Company is thereby accused of being partisan and biased in favor of the [medical] profession, so be it. The Company is totally biased in this regard.

The Commentary quotes an *American Bar Association Journal* article in the following manner:

Until recently, malpractice claims against doctors had only a remote chance for success in New Jersey's courts. Now, however, a new, more equitable procedure for handling these claims has been established.

The Company interprets the above statement to mean that before the advent of the panel, New Jersey physicians could hope to be successfully defended in court, but now they are not so secure.

It is apparent that a major reason for the failure to make use of the panel procedure in many areas is the adverse posture assumed by the insurance companies. While it is clear that this is in the best interests

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25. Id. at 1.
26. Id. at 7-8.
27. Id. at 8.
of insurers, it is also clear that the public interest in gaining relief for meritorious claims, and also the long run interests of the medical profession, are harmed.

*Do Panels Help Stabilize the Cost of Malpractice Insurance?*

It is impossible to answer this question with absolute certainty. The best answer is: "probably not." From the standpoint of the medical profession, this was one of the primary goals of the screening boards. To the consternation of the profession, however, two of the most smoothly operating panels, the Pima County and the New Mexico panels, admit that the possibility of reducing insurance costs has proved to be quite slim. The reason appears to be that insurance rate schedules are not determined on a state-by-state basis. For example, Nevada, with a successful screening panel, has had good insurance experience since the formation of the panel, and physicians there might expect a low rate schedule. But insurers group states by geographic regions for purposes of premium computations for resident physicians. Nevada is grouped regionally with Southern California, an area where insurance companies experience a staggering loss factor each year. As a result, Nevada physicians have seen their malpractice insurance rates increase more than 110 percent from 1966 to 1970.28

Thus, the physicians practicing in a state which enjoys a successful screening panel will not receive the expected lower malpractice insurance rates so long as that state continues to be grouped for the purpose of insurance rate-making with a state which has not established effective panels. The obvious answer to this problem is to force insurance companies to compute rates on a state-by-state basis, but until this is done, it is unlikely that medical-legal screening panels will have any effect on insurance rate schedules for participating physicians.

*Effect on the Number of Prompt Settlements of Meritorious Claims.*

All indications point to the conclusion that the screening panels significantly increase the number of prompt settlements of provable claims. Medical societies, however, keep no records of claims and settlements, and insurance carriers have been unwilling to furnish the information necessary for a positive determination. The only insurance company which submitted a relatively complete and thoughtful reply was the

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St. Paul Insurance Companies. But concerning the number of claims and settlements, the St. Paul Companies joined the other carriers in responding:

[To] comply would demand an exhaustive study of each individual claim file as our computer programming is not set up to develop the information at this stage; therefore we are sorry we cannot comply.  

However, even in the absence of meaningful responses, it seems clear that as the number of malpractice claims decided by the screening panel increases, the number of prompt settlements of meritorious claims must also increase.

No data is available on the number of claims which are settled without resort to either the screening panel or the court. It is assumed by those involved with malpractice litigation that those claims which are settled without resort to panel or court would not be affected by the presence or absence of a screening panel. This assumption appears to be justified from the standpoint of logic. If an insurance company regards a claim to be so clearly provable as to forego its right to defend in court, it seems unlikely that the insurer would find it financially expedient to litigate the same claim before a screening panel.

**EFFECT OF PANELS ON SETTLEMENTS OF MERITORIOUS CLAIMS**

<table>
<thead>
<tr>
<th>Decision for Patient</th>
<th>Pima Co.</th>
<th>Colo.</th>
<th>N.M.</th>
<th>Mont.</th>
<th>Seattle</th>
<th>Spokane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Settled</td>
<td>20</td>
<td>5</td>
<td>30</td>
<td>3</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Subsequent Court Action</td>
<td>20</td>
<td>4</td>
<td>30</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

* Of the four cases which proceeded to trial, the physician twice prevailed and the other two are still pending.

Washoe County, Nevada, an otherwise successful panel has seen only about 40 percent of its decisions in favor of plaintiff settled.

New Jersey has the unique provision that the parties may contractually agree to make the decision of the panel binding. As a result, few cases decided by the New Jersey panel are subsequently litigated. If the New Jersey panel decided a substantial percentage of malpractice claims, as contrasted with the 17 percent it does hear, the panel would reduce the number of court actions to almost zero.

The exception to this is the so-called “nuisance claim,” where the claim’s validity is highly suspect, but the cost of defense would be

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substantially in excess of the amount of the claim. These are the claims which heretofore have been settled by the insurance carriers, much to the displeasure of the medical profession, which believes such conduct encourages the continued fabrication of these questionable claims.

The presence of medical-legal panels has probably reversed this practice of settling nuisance claims, at least in states such as New Mexico, Arizona, and Nevada, where substantially all claims are submitted to screening panels.

For meritorious cases however, the compiled data indicates, and panel members—both physicians and attorneys—believe, that screening panels have significantly increased the number of prompt settlements.

*Expert Testimony Provided for Meritorious Claims.*

A section in the by-laws of each panel provides that experts will be furnished to a patient who is determined by the panel to have a reasonable claim, if that claim is subsequently litigated in court. All panels responding stated that experts were furnished to all claimants in subsequent trials. However, no case data was available which would substantiate the assertion that each plaintiff who had prevailed before the panel was later supplied with expert testimony when his claim was subsequently heard in court.

The provisions of the New Mexico screening panel are more expansive than most panel provisions with regard to providing expert medical advice. Although typical in the provision that each claim is decided by the panel, the New Mexico procedure further requires that each claimant will have access to expert advice *before* the submission of his claim to the panel. It is asserted that this procedure serves three purposes:

(1) It aids the claimant’s attorney in the timely isolation of the medical issues involved;
(2) It provides advice to the claimant’s attorney concerning the strengths and weaknesses of the case, thus facilitating a forceful presentation of the claim; and
(3) It helps to eliminate at the pre-hearing stage those claims which show no possibility of professional negligence.

Thus, although supporting data is unavailable, every indication is that claimants are being provided with expert medical testimony when settlement is not achieved and the case continues to trial after a panel decision for the claimant.
The Effects of the Panels' Decisions on Subsequent Court Claims.

With the exception of the New Jersey panel which provides that the parties may agree to be bound by the decision of the panel, the decisions of the panels are not binding.

### Effect of Decision for Doctor on Subsequent Litigation

<table>
<thead>
<tr>
<th></th>
<th>Phila.</th>
<th>Pima Co.</th>
<th>Colo.</th>
<th>N.M.</th>
<th>Mont.</th>
<th>Spokane</th>
<th>Seattle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases Found for Doctor</td>
<td>14</td>
<td>42</td>
<td>13</td>
<td>66</td>
<td>11</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>Cases Dropped</td>
<td>7</td>
<td>39</td>
<td>12**</td>
<td>57</td>
<td>11</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Cases Subsequently Litigated</td>
<td>7</td>
<td>3*</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>10***</td>
</tr>
</tbody>
</table>

* All three cases resulted in verdicts for the doctor.
** One case was settled before subsequent litigation.
*** Two cases were won by the patient, two by the doctor, and six are pending.

As a general rule, in those states where there is a high degree of cooperation between the two professions (a characteristic of a successful panel), few cases decided by the panel in favor of the physician subsequently reach the courts. Furthermore, in these states the practice of ignoring panel decisions is strongly discouraged by the bar association.

Where the panel decision is favorable to the claimant, the primary reason for subsequent court action is the inability of the parties to agree on a dollar value for the claim. Some insurance companies privately contend that after a favorable panel decision, claimants make unrealistic demands in settlement negotiations, and they assert that this is a primary factor in the failure to reach agreement. No evidence was found which would serve to support or refute this contention.

An adverse decision by the panel unquestionably makes the procurement of expert testimony, at least within the specific locality, a much more difficult task than normal. But all panels stipulate that any evidence of the panel decision, or even any mention of the panel hearing, is inadmissible in a court of law. Therefore, at least at the trial level, neither party is prejudiced by a prior panel finding.

There may be, however, one crack in the wall of confidentiality. In a Nevada case, *Nichter v. EDMONSTON*, the supreme court held that not all matters before the panel were privileged, since the signed agreement of confidentiality expressly mentioned only the members of the panel. Therefore, it was found that the plaintiff should have been allowed to offer into evidence a statement allegedly made by the defendant to the panel for the purpose of impeaching the defendant.

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31. Id.
The wording of the agreement signed by the parties submitting cases before many of the panels is similar to the Nevada agreement in *Nichter*, and therefore is subject to similar attack. This would seriously impair the effectiveness of the panels. It is a problem which must be remedied quickly by all affected panels. The solution, however, appears to be very simple—the agreement of confidentiality must be expressly expanded to cover both panel members, plaintiff and defendant, and all who are present or who have access to information adduced before the panel.

**Conclusion**

Medical malpractice screening panels are, at best, only partially successful. While in theory they appear to provide an ideal alternative to the traditional trial method for handling medical malpractice claims, the fact is that in many areas the panel approach has been a near or total failure. As they are presently organized, the panels depend upon two variables for their success. The first variable is the total cooperation and dedication of the medical and bar associations to making the procedure work. The second variable is the cooperation of the insurance carriers in allowing claims to be presented to the panel.

In densely populated areas, the cooperation necessary between the legal and medical professions often has been lacking. Conversely, in rural areas the panel seems to work rather well.

The cooperation of the insurance carriers has been withheld due to the existence of several shortcomings of the panel procedure which the insurance companies are quick to present. One complaint is that the decision of the panel is not binding on the parties. The other complaint is that not all malpractice claims are submitted to the panel.

Two of the major professional liability carriers, the St. Paul Companies and The Medical Protective Company of Ft. Wayne, have indicated that they might be more willing to accept a medical-legal screening panel procedure if the decisions were final. As to existing procedures, the insurance carriers feel that the mechanism is weighted in favor of the plaintiffs.

Although the panel procedure has worked well in some areas, two ubiquitous problems exist which have caused the panel procedure to fail in other areas and which jeopardize the expansion of medical-legal review panels to a national scale. These are the same problems which the insurance companies have emphasized, namely: submission of cases to the panel is voluntary, and the decision of the panel is not binding.
For these reasons the medical-legal screening panel procedure for medical malpractice claims, as presently constituted, is not the most desirable alternative to the traditional trial procedure on a national basis. Unless all cases are submitted to the panels, the effect of the procedure on the cost of professional liability insurance would be negligible. As a result, the cost to the public of medical care would not be significantly reduced or stabilized.

A high percentage of cases by-passing panel consideration, or subsequently litigated after panel decision, will also serve to continue the trend toward the practice of defensive medicine by physicians fearful of potential malpractice court actions.

Not to be overlooked, however, is the one predominant advantage of the medical-legal screening panel concept over the trial approach. The panel is infinitely more competent to decide the question of liability than a jury of laymen. Due to their expertise, the medical-legal panels are much more likely to be able to differentiate between a meritorious and a frivolous claim. Additionally, the improved availability of expert witnesses under panel procedures can only serve to enhance the possibility of a just disposition of a malpractice claim.

But the problem remains that all malpractice claims must be required to be adjudicated before a medical-legal screening panel, and that the decision of the panel be final. Without these provisions, the prognosis for the success of the panel procedure as a cure for the diseases which exist within the traditional trial approach in the area of medical malpractice is poor.

There are, however, alternative procedures which might be more desirable than the screening panel. Compulsory arbitration would not suffer from the disadvantages peculiar to the screening panel procedure. It would satisfy the insurance carriers' complaint concerning the non-compulsory nature of the medical-legal screening panels, and at the same time might be made more palatable to the litigants by limiting the arbitration board's decision to the issue of liability and allowing damages to be determined by a jury if the parties cannot settle among themselves. Arbitration procedures for medical malpractice are now being tested in New York City and Los Angeles, two areas which traditionally experience a great volume of medical malpractice litigation. The results of these programs may be indicative of what lies ahead for malpractice claims.

A different approach is one which ignores the concept of professional negligence entirely. Accepting the fact that there is risk involved
in every medical treatment, and that negative unforeseen results sometimes occur for a variety of reasons, often absent any negligence on the part of the physician or hospital, a specially-devised insurance program might alleviate many of the hardships of the traditional trial approach. This insurance could be included in an individual's health insurance plan or in a national health insurance plan, should such a plan become a reality in the future. For a small premium, any patient suffering a negative result from medical treatment would receive compensation for the injury without regard to the presence or absence of negligence by the physician or hospital. Any workable plan of this type would necessarily be complex and sophisticated in order to provide adequately for such things as a satisfactory compensation schedule, and a detailed proposal is beyond the scope of this paper.

It does seem clear, however, that it has become necessary to provide for an alternative method of handling malpractice claims. Furthermore, such a method must be conceived before present problems become intolerable. And the conclusion must be reached that, while they have been successful in some areas, medical-legal screening panels are not, as presently constituted, an acceptable alternative solution to this urgent problem of national concern.