MEDICOLEGAL UPDATE

MASSACHUSETTS' EXPERIENCE WITH MALPRACTICE PRE-TRIAL SCREENING

Back in January of 1976, the Massachusetts legislature, in response to a so-called malpractice crisis, established a state regulated medical malpractice insurance program designed to screen out the frivolous cases which clog the court system and add to insurance costs. Under the program, before a medical malpractice case can go into court, it must be deemed legitimate, as opposed to being simply an unfortunate medical result, by a screening panel composed of a superior court judge, a lawyer, and a physician or other representative of the area of medicine involved.

The evidence now available indicates that the tribunal system is working, and has both lightened the judicial workload and relieved defendant physician anxiety. Although not necessarily related to the imposition of the tribunal, the number of medical malpractice cases filed in Massachusetts has leveled off, and insurance rates have remained relatively constant.

The statistics on the period January 1, 1976, through July 11, 1977, indicate that more than half the cases heard by the tribunal have been rejected. The main dollar savings resulting from the panel have, therefore, been in costly pretrial discovery devices, such as interrogatories and depositions. Out of 503 cases filed; 101 were approved, 119 rejected, bond was posted in 29, partial approval was granted in 21 cases, 24 cases were dismissed before reaching the tribunal, and 227 cases are still pending.

According to persons familiar with the tribunal system, the fact that half the cases heard are rejected is attributable to the fact that: 1) many cases *are* frivolous; 2) physicians are still reluctant to testify against fellow practitioners; and 3) some attorneys going before the tribunal lack specific experience with medical malpractice actions.
(Source: Boston Globe, Monday, March 6, 1978. p. 1)

MERITS OF ARBITRATION SHOWN IN MALPRACTICE STUDY

A study supported by the National Center for Health Services Research found that the medical malpractice costs of a group of hospitals with an arbitration option were significantly less than a comparable group of hospitals that did not utilize arbitration. The study found that average settlements and paid losses per closed claim were 15.3 percent less in the arbitration group.

The study, directed by Duane H. Heintz, Director of Finance and Insurance for the Iowa Hospital Association, studied eight hospitals in the Los Angeles area and describes the first hospital-based arbitration experiment in the country. The study also found that proportionately fewer claims of medical malpractice were filed against the arbitration group of hospitals than against the comparative group. Further, the length of time between the filing of a claim and its resolution was three months shorter for the arbitration group.

The final report of the study, which was entitled, *An Analysis of the Southern California Arbitration Project, January 1966 through June 1975,* DHEW Publication No. (HRA) 76-3159, is available from the National Center for Health Services Research, Health Resources Administration, 3700 East-West Highway, Hyattsville, MD 20782.

In a related development, a Pennsylvania court sustained as constitutional a 1975 law which required pretrial review of medical malpractice suits by an arbitration panel. The court rejected arguments that arbitration places an undue burden on the plaintiff's right to a jury trial, that the arbitrator had been improperly vested with judicial powers, and that the appointment of health care providers to the arbitration panel violated the impartiality required under due process. Holding that the panel's findings and award may not be introduced in evidence at a subsequent court proceeding, the court failed to find that arbitration posed an impermissible burden to the plaintiff's access to the courts.

MALPRACTICE RECOMMENDATIONS

Health Perspectives, the newsletter of the Consumer Commission on the Accreditation of Health Services, Inc., recently made the following suggestions concerning the medical malpractice "crisis:"

1) All physicians or medical facilities with more than one malpractice suit against them should be subject to state review for purposes of license revocation, with peer review available to suggest intermediate actions or procedures where desirable.

2) Consideration should be given to establishing a group of physicians under governmental auspices to provide impartial medical testimony at malpractice hearings.

3) Malpractice premium rates should be related to the volume of practice and to malpractice experience, so that competent physicians are not penalized for the actions of less competent physicians, and younger physicians are not rated at the same level as physicians who have established practices and larger incomes.

4) Physicians and hospitals should be required to co-insure malpractice coverage.

5) Federal and state insurance funds should be established to co-insure the large-risk claim.

6) No adjustments in the system of malpractice insurance should abridge the rights of consumers to seek redress in the courts where they have suffered medical injury due to physician or institutional negligence.

7) Binding arbitration should be available to patients and professionals for small cases which are not large enough to require a jury trial.

8) All physicians should be required to participate in continuing educational programs, and periodically be retested on current standards of practice, new diagnostic procedures and physician-patient relationships and responsibilities.