Health Care Providers and Alternative Dispute Resolution: Needed Medicine to Combat Medical Malpractice Claims

I. INTRODUCTION

The volume of medical malpractice litigation in the United States has increased rapidly since 1950. An upward trend in personal injury litigation, increased expectations about good health and "miracle cures,"[1] and the opportunities to receive substantial judgments for damages[2] have greatly fueled lawyers' and patients' decisions to sue all categories of health care providers. As a result of the frequency and severity of malpractice litigation, commercial insurance carriers raised the cost of liability insurance for health care providers,[3] which compelled the providers to pass along these costs to their patients. By 1974-1975, a malpractice "crisis" culminated throughout the nation, a crisis described by the Secretary's Commission on Medical Malpractice as:

> A problem of national concern that vitally affects the way in which health care is rendered in this country. The malpractice problem is like a proliferation of cancerous cells which has spread throughout the health care system. Its consequences . . . are indeed profound.[4]

As the health care system headed toward a possible collapse in the mid-1970s, consumer groups, physicians, hospitals and insurance companies began pressuring state officials across the country to fix the shortcomings in the existing malpractice system. State legislatures thus undertook an examination of several alternative approaches to the problem, ranging from tort reform measures to expanding the sources for malpractice liability insurance.[5] Two principal alternatives which several states implemented were *pre-trial screening panels*[6] and *arbitration.*[7] These mechanisms were aimed at encouraging malpractice settlements and fostering more equitable claims procedures outside the traditional court system, for the benefit of all parties involved.[8]

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1. P. CARLIN, MEDICAL MALPRACTICE PRE-TRIAL SCREENING PANELS: A REVIEW OF THE EVIDENCE 9 (1980). Miracle cures refer to expectations that doctors can treat successfully even the most difficult medical conditions.
2. *See id.* at 10.
3. *See id.* For example, average premiums increased two-fold during 1974-1977.
4. *Id.* at 8.
5. *Id.* at 13.
6. *See id.* at 15. Presently 26 states operate screening panels.
7. For background information on arbitration, see generally Ladimer, Solomon & Mulvihill, *Experience in Medical Malpractice Arbitration,* 2 J. LEGAL MED. 433, 444 (1981). Presently 14 states operate arbitration mechanisms.
8. *See* P. CARLIN, *supra* note 1, at 12.

The successes and failures of alternative dispute resolution in the medical malpractice forum have had a significant impact on efforts to revitalize the current United States health care system. The focus of this Note is to examine the use of screening panels and arbitration of malpractice claims, principally from the perspective of health care providers, including physicians, hospitals and Health Maintenance Organizations (HMOs).[9] Issues for consideration are whether alternative dispute resolution mechanisms are effective in attaining the goals of health care professionals and institutions, and how screening panels and arbitration, if beneficial, can be better used. The position of this Note is that to varying extents alternative dispute resolution can benefit and sustain the interests of both health care providers and their patients. As a result these two mechanisms, when implemented with reforms, can improve the overall structure of the health care system.

A. *Historical Overview of the Malpractice Problem*

The malpractice crisis of the 1970s hit health care providers hard across the United States. For example, in New York State, from 1970 through 1974, the number of cases filed against physicians rose from 564 to 1,200, and the average cost of settling a malpractice claim during the decade climbed from $6,000 to $23,400.[10] Consequently, malpractice insurance premiums soared, causing hospitals in some cases to pay six times the amount of liability insurance in 1977 that they paid in 1974.[11] When the increased cost of health care threatened the stability of the entire health care industry, providers and patients turned to their respective state governments for immediate relief.

B. *Initial Responses by Governmental Authorities: Screening Panels and Arbitration*

When the states began tackling the medical malpractice crisis, two general goals were pursued, both of which still exist today. The first goal consisted of reducing the number of malpractice claims filed, as well as decreasing the time and expense involved in conventional litigation.[12] The second goal was to reduce the awards given to plaintiffs in malpractice actions.[13] Various proposals were considered, including

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9. For a general discussion on Health Maintenance Organizations, see B. FURROW, S. JOHNSON, T. JOST & R. SCHWARTZ, HEALTH LAW 392-94 (1987) [hereinafter HEALTH LAW]. Health Maintenance Organizations are health care organizations which administer care to patients on a prepaid, as opposed to a fee for service, basis. *Id.*

10. *See* P. CARLIN, *supra* note 1 at 9-10.

11. *Id.* at 10.

12. *Id.* at 3-4; Terry, *The Technical and Conceptual Flaws of Medical Malpractice Arbitration*, 30 ST. LOUIS U.L.J. 571, 572 (1986).

13. *Id.*

substantive tort law changes such as shortened statutes of limitations, dollar caps on malpractice verdicts, stricter expert witness rules, and control over attorney contingency fees.[14] Two of the proposals examined came from the area of non-conventional litigation: pre-trial screening panels and arbitration.

Screening panels are designed to supplement the traditional legal system. Panels consisting of lawyers, doctors, lay persons, or judicial officers hear cases and reach opinions on issues of liability and sometimes damages. To influence negotiation and party settlement as well as to protect the constitutional right to a jury trial, all screening panels place emphasis upon access to the courts for final disposition.[15] Arbitration, on the other hand, avoids the traditional court system by providing a parallel private forum for malpractice claim resolution. Frequently, arbitration panels have the power to make *final* determinations of liability which are legally enforceable.[16]

II. HEALTH CARE PROVIDERS AND THE NEED FOR ALTERNATIVE DISPUTE RESOLUTION

By implementing screening panels and arbitration, state governments believed the goals of reducing the frequency and severity of malpractice claims could be attained. From the point of view of individual and institutional health care providers, however, these goals have been only partially achieved in the last decade. Nevertheless, alternative dispute resolution for health care providers remains an important and useful concept, in theory as well as in practice.

A. *The Goals of Health Care Providers When Resolving Malpractice Claims*

Health care providers continue to share many of the same goals which state legislatures advocate in alleviating the malpractice problem persisting throughout the 1980s. Health care providers desire to remain in business, and vital state interests are served in maintaining community access to health care resources and services. Consequently, all parties benefit from the reduction in the frequency and severity of lawsuits against physicians and hospitals because lower costs from decreasing insurance rates enable providers to continue the delivery of health care services.[17]

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14. *Id.* at 13.
15. *See* Ladimer, Solomon & Mulvihill, *supra* note 7, at 444.
16. *Id.*
17. *See* P. CARLIN, *supra* note 1, at 3-4.

The principal goals of health care providers revolve around the need to reduce frivolous lawsuits and to settle with plaintiffs clear claims of provider liability.[18] Providers also desire to keep claims away from jury evaluation so as to diminish high damage awards,[19] thereby reducing the high cost of insurance premiums. Furthermore, if the costs of defending malpractice actions diminish, the quality of health care administered by providers may in fact improve. Doctors will focus more attention on administering health care rather than on malpractice matters. Thus, screening panels and arbitration, by removing claims from the traditional litigation process, potentially foreclose severe provider liability while enhancing the quality of patient care.

B. *Screening Panels and Arbitration: The Basics Behind Non-Conventional Litigation*

The structure of screening panels varies by jurisdiction. For example, New York State has a panel where a supreme court (court of first instance) justice or retired justice, an attorney, and a physician determine liability,[20] while New Mexico's panel includes three health care providers and three attorneys, with a chairperson attorney on hand to vote in case of a tie.[21] Moreover, procedural devices such as the use of panel findings as evidence in a later trial also differ across jurisdictions. In New Jersey, panel findings are admissible at a subsequent trial;[22] yet, in New York, panel determinations are admissible at trial only if decided unanimously.[23]

While screening panels can possess structural and procedural differences, they are uniformly used to screen out frivolous lawsuits and determine meritorious malpractice claims which should be settled quickly. Additionally, if parties desire to proceed to trial, panels can make certain recommendations which may aid the court in resolving the dispute. Given the purpose of the panels, however, several states implement penalties against screening panel losers who institute subsequent litigation.[24] The goal is to strongly encourage the less expensive and less administratively difficult pre-trial process.

The other mechanism of alternative dispute resolution used by several states, the impartial arbitration process, shares many similarities with medical malpractice screening panels. As is the case with screening

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18. *See* Terry, *supra* note 12, at 572.

19. M. REDISH, LEGISLATIVE RESPONSES TO THE MEDICAL MALPRACTICE CRISIS: CONSTITUTIONAL IMPLICATIONS 13 (1977).

20. N.Y. JUD. LAW § 148a (McKinney 1983 & Supp. 1988).

21. N.M. STAT. ANN. §§ 41-5-17, 41-5-20 (1986).

22. N.J. SUP. CT. R. 4:21-6(e) (1988).

23. N.Y. JUD. LAW § 148a (McKinney 1983).

24. *See* P. CARLIN, *supra* note 1, at 25. An example of such a penalty is a bond-posting requirement.

panels, the structure of arbitration varies across jurisdictions. For example, Alaska's panel consists of three members: one designated by the claimant, one designated by a health care provider, and one (a chairperson) designated by mutual agreement.[25] The Pennsylvania arbitration panel consists of three different members made up of one health care provider, one attorney, and one layperson.[26] It is important to note, however, that no state currently requires compulsory arbitration for medical malpractice claims.

Like screening panels, medical malpractice arbitration systems attempt to reduce the overall costs of resolving malpractice disputes. However, while screening panels are designed to screen out nonmeritorious claims and find meritorious ones which can be settled expeditiously, arbitration is geared more toward finally resolving patient-provider disputes. In essence, arbitration seeks to replace the conventional malpractice trial process with final decisions reached quickly, economically, and confidentially.[27] Screening panels, in contrast to arbitration, seek to assist or supplement jury trials.[28]

C. *Screening Panels and Arbitration: Advantages and Disadvantages to Health Care Providers*

For health care providers, screening panels possess some basic advantages and disadvantages. First, the panels are less formal and less time consuming than the conventional adversarial process, which keeps down malpractice costs for providers.[29] Second, screening panels consisting of attorneys and health care professionals are usually better informed on malpractice issues than lay juries, which leads to more accurate decisions.[30] If such decisions are more reasoned or thoroughly examined, providers will be less susceptible to the whims of sympathetic jurors, who often lack the necessary expertise to determine malpractice liability in many complex cases. As a result, provider insurance rates will likely decrease, with a greater consistency in favorable panel decisions.[31]

The principal disadvantage of screening panels for physicians and hospitals lies in the fact that panels will only delay dispute resolution, because plaintiffs will proceed to trial anyway in the absence of a binding panel decision. Hence, it may cost even more for a provider to

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25. ALASKA STAT. § 09.55.535(f) (1986).
26. PA. STAT. ANN. TIT. 40, § 1301.308 (Purdon Supp. 1987).
27. Sayakan, *Arbitration and Screening Panels: Recent Experience and Trends*, 17 FORUM 682, 685 (1982).
28. HEALTH LAW, *supra* note 9, at 280.
29. *See* P. CARLIN, *supra* note 1, at 15.
30. HEALTH LAW, *supra* note 9, at 280.
31. *See* P. CARLIN, *supra* note 1.

defend an action that proceeds through the panel system and then to trial. Another provider concern is that screening panels often favor health care professionals, thereby raising the question of bias or prejudice against plaintiffs. Such accusations create time delays in the panel dispute resolution process, which again translates into increased expenses for provider-defendants.

The advantages which arbitration brings to health care providers, as well as plaintiffs in the action, include the speedier handling of claims, relaxed rules of evidence, and narrow grounds for appealing panel decisions.[32] This latter circumstance benefits providers because plaintiffs will have difficulty appealing liability or damage determinations upon favorable rulings. The panels also have an advantage in that they allow both parties to present their case to qualified experts. For providers, this advantage becomes especially useful when fellow health care professionals administer or sit on the arbitration tribunals.

Although arbitration reduces the caseload burden on courts and enables fact-finding to take place apart from courtroom theatrics,[33] disadvantages do exist. For provider-defendants, the biggest disadvantage is that arbitration encourages nuisance suits or excess filing of frivolous claims.[34] Essentially, where arbitration proceedings are available, a claimant has nothing to lose by trying to win at arbitration with a claim that otherwise would be dismissed in court. The result is that providers will potentially have to litigate an action twice if they choose to appeal what they believe is a plaintiff's undeserved arbitration victory, a situation which can become very costly.[35]

D. *Note: The Constitutionality of Arbitration Provisions*

One other important concern involves the due process rights of a claimant to seek a jury trial and avoid alternative dispute resolution. As the focus of this Note is on health care providers and not patients, a full examination of constitutional rights is inappropriate for present discussion. It should be noted, however, that courts have held voluntary arbitration provisions of state malpractice statutes to be consistent with the constitutional guarantee of jury trials.[36] Suffice it to say, screening panels and arbitration provisions are constitutional in most circumstances.[37]

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32. *See* Sayakan, *supra* note 27, at 684.

33. *Id.* at 684.

34. Silas, *Medical Arbitration is on a Rocky Road*, 10 A.B.A. BAR LEADER 9 (1984).

35. *Id.* Undeserved victories result when panels are not fully informed in evaluating cases. Maryland's arbitration panel is an example of the variation level in panel experts.

36. *See* Morris v. Metriyakool, 418 Mich. 423, 344 N.W.2d 736 (1984). McLean v. Hunter, 486 So. 2d 816 (La. Ct. App. 1st Cir. 1986) (upholding constitutionality of submitting malpractice claims to medical review panels).

37. *See generally* M. REDISH *supra* 19; Note, *Constitutional Standards of Review for Medical Malpractice Mediation Panels*, 1 OHIO ST. J. DIS. RES. 183 (1985).

III. Resolving Malpractice Disputes with Screening Panels and Arbitration: Measuring Effectiveness in Practice

In practice, screening panels and arbitration have achieved several of the above-mentioned goals of individual and institutional health care providers.[38] Furthermore, patients have benefitted in many respects from resolving malpractice claims outside the conventional litigation process. Several goals of both parties, however, have yet to reach satisfactory levels. The following sections examine some of the screening panel and arbitration programs implemented, focusing on the overall effectiveness of such programs in alleviating the malpractice problem.

A. *Screening Panels and the Attainment of Health Care Providers' Goals*

1. *Early Studies.* In the 1970s, the first screening panels were established as legislative responses to the malpractice crisis. One of the early studies done to measure the effectiveness of screening panels was the 1977 study of Philip and Faust for the Institute of Judicial Administration.[39] Essentially, the authors concluded through interviews that panel findings appeared to be impartial and fair.[40] Philip and Faust stated, however, that not enough data had been analyzed to declare with certainty screening panel effects on the rate of claim disposition or insurance premium reduction.[41]

Although early studies such as Philip and Faust's did not firmly provide vital information on screening panels' ability to reduce the flow of frivolous claims, results in some jurisdictions indicate that the panels encouraged settlements and dismissals. For example, in New Mexico, settlements followed in seventy-three percent of the cases where negligence was found, and in seventy-three percent of the cases where no negligence was found, cases were subsequently dropped or dismissed.[42] In comparison, fewer settlements occurred when cases proceeded to trial without panel review.[43] In New Jersey, however, the authors found that many parties were bypassing the voluntary screening panels because such panels had "no teeth."[44] Consequently, a plaintiff with a poor claim could nevertheless proceed to litigation in New Jersey because screening

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38. *See* Terry, *supra* note 18 and accompanying text.
39. C. Philip & R. Faust, Medical Malpractice Panels in Four States *passim* (1977).
40. *Id.* at 39.
41. *Id.*
42. *Id.* at 26.
43. *Id.*
44. *Id.* at 30-32.

panels, often plagued with staffing problems, had no authority to dispose of nonmeritorious claims.[45]

2. *The Carlin Study.* In 1980, Peter Carlin of the Intergovernmental Health Policy Project produced a much more thorough evaluation of medical malpractice screening panels than that in Philip and Faust's study. Carlin's study focused on how the structure and impact of panels were meeting the basic goals of screening out and disposing of costly malpractice claims.[46] Carlin found that despite structural differences across jurisdictions, panel systems in many states have reduced the volume of malpractice cases that ordinarily proceed to litigation. Additionally, Carlin's results indicated that screening panels render prompt decisions; hence, they resolve liability disputes quicker than conventional litigation.[47]

For example, in 1976 through 1978, New York's panel recommendations resulted in a settlement rate before trial of sixty-six percent.[48] In Hawaii, seventy-two percent of the cases which found provider liability at the screening level were settled, and fifty-four percent of the cases finding no provider liability were dropped.[49] Furthermore, in New Jersey, panel decisions were rendered in one day or even in a few hours.[50] As Carlin's evaluations in New Mexico, Hawaii, and Wisconsin indicate, the informal nature of the proceedings also was found to help the pace of claim resolution from the reporting of the incident to panel determination.[51]

Although Carlin notes problems in many states, most involving delays in panel selections and proceedings,[52] health care providers have to be encouraged by the results of panels in several locations. If less disputes are reaching the courts and claims are being settled quickly, malpractice awards and litigation costs are bound to decrease for provider-defendants. Perhaps the most important statistic noted by Carlin, however, is that at the time of his study, health care providers were winning nearly eighty percent of all screening panel decisions.[53] Consequently, providers are put in an advantageous position to force settlement or abandonment of claims by the opposition,[54] with the added bonus of potential penalties being administered against those plaintiffs who appeal losing verdicts.

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45. *See id.* at 32.
46. *See* P. CARLIN, *supra* note 1, *passim.*
47. *Id.* at 39.
48. *Id.* at 31.
49. *Id.*
50. *Id.* at 34.
51. *Id.*
52. *Id.* at 32.
53. *Id.* at 29.
54. *Id.* at 32.

Such a rate of provider success, however, leads to accusations of bias on screening panels, especially where health care providers make up the majority of panels. Consequently, plaintiffs with potentially valid claims feel helpless and angry because they believe they will not be compensated for a provider's negligence. Such a situation can work as a disadvantage to providers, principally in those jurisdictions where patients are most able to bypass a panel's recommendation without any disincentives for doing so.[55] As a result, providers and patients remain adversaries, which only inhibits negotiations for cost-reducing settlements and claim resolutions.

3. *Current Evaluations.* Presently, there are a few evaluations which expand on Carlin's findings. Two states where the usage of medical malpractice screening panels has been examined are Maryland[56] and Virginia.[57]

In Maryland, malpractice claims in excess of the limit established by the District Court's concurrent jurisdiction must be submitted to the Health Claims Arbitration Office (HCAO), which functions as a pretrial screening mechanism.[58] The panel which hears the case consists of an attorney, a health care provider, and a lay person. "The panel is not required to follow formal rules of evidence. However, it does have the authority to determine defendant liability and to award damages if appropriate."[59]

The results of the panel's ten year existence show that only ten to fifteen percent of panel decisions are actually tried in the circuit courts on appeal,[60] which points to a reduction in the existing logjam currently facing the courts.[61] Also, Maryland's statute[62] requires a certificate of merit be filed showing the defendant doctor deviated from the standard of care and caused the plaintiff's injury. This device has served to reduce the number of claims filed by fifty percent in 1986.[63] Panel awards, however, have not been reduced, as panels are often more generous than their jury counterparts.[64] Finally, claim resolution is frequently delayed, though not to the levels of traditional litigation, because

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55. *See* C. PHILIP & R. FAUST, *supra* note 39, at 30-33, 39.

56. Heller, *Health Care Arbitration System in Maryland Still Evokes Controversy*, 1 Altern. Dis. Res. Rep. (BNA) 219 (Sept. 17, 1987).

57. *See generally* Daughtrey & Smith, *Medical Malpractice Review Panels in Operation in Virginia*, 19 U. RICH. L. REV. 273 (1985).

58. Maryland Health Claims Arbitration Act, MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-02 (Supp. 1987).

59. *See* Heller, *supra* note 56.

60. *See id.* In Maryland, 40 percent of panel decisions are appealed; 10 to 15 percent of these decisions are actually tried again.

61. *Id.*

62. Maryland Health Claims Arbitration Act, MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-04 (Supp. 1987).

63. *See* Heller, *supra* note 56, at 220.

64. *Id.* at 219.

parties do not adhere to time limitations (for serving answers, selecting panel members) imposed by the Maryland Act.[65]

Determining whether the Maryland system is successful depends on whom is asked. Attorneys on both sides see the panel process as an extra step resulting in double litigation, while physicians favor the system because on the whole, few cases reach juries.[66] For some physicians, the process would work much better if the panels were given more authority, and doctors were willing to spend the time reviewing the conduct of their colleagues. Overall, however, the system seems to be eliminating meritless cases,[67] which ultimately benefits providers and the burdened court system.

In Virginia, the Medical Malpractice Act of 1976, amended in 1984,[68] which was the focus of Daughtrey and Smith's evaluation,[69] also established review panels with the purpose of containing the cost of medical malpractice insurance by keeping clearly meritorious and frivolous claims out of the court system. Like Maryland, the panel is comprised of attorneys, health care providers, and laypersons. Moreover, the statute designates that at least one provider on the panel represent the medical specialty involved in the malpractice claim.[70]

In reviewing Virginia's screening panels, Daughtrey and Smith concluded that the system is perceived as fostering the goals of speed and cost containment in resolving disputes arising out of malpractice allegations.[71] While the authors suggest more data is needed to judge the panels' full effectiveness, it is evident that at least on the issue of burdens to participating parties, panels do not cause oppressive delays in the final resolution of malpractice disputes.[72] This finding is crucial for providers since plaintiffs will stay with the panel procedure instead of proceeding to courts that possess sympathetic juries. Additionally, without delays, plaintiffs will have difficulty arguing that time-consuming panels serve to infringe on constitutional rights to trial.[73]

In conclusion, screening panels appear to reduce the number of malpractice claims which ultimately proceed to litigation. If providers can somehow keep the panels free of accusations of bias, they should subsequently benefit from this mechanism.[74]

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65. *Id.*
66. *Id.* at 222.
67. *Id.* at 220.
68. VA. CODE ANN. § 8.01-581.1 (Repl. Vol. 1984 & Supp. 1988).
69. *See* Daughtrey & Smith, *supra* note 57.
70. *Id.* at 292.
71. *Id.* at 298.
72. *Id.* at 296.
73. *Id.* For an example of a case holding that panel delay is unconstitutional, see Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980).
74. Of course, it is arguable that to a large extent, bias among screening panel members is an *advantage* for health care providers. Providers cannot benefit from biased

B. *Arbitration and the Attainment of Health Care Providers' Goals*

Arbitration, on the other hand, has travelled down a somewhat rockier road than screening panels. Malpractice and arbitration provisions have come under constitutional attack because the right to trial can be taken away.[75] Yet, even with constitutional problems, arbitration panels, like pre-trial screening tribunals, have alleviated some aspects of the malpractice problem. Basically, arbitration resolves disputes in shorter periods of time than litigation does,[76] and for institutional providers, it reduces the number of claims filed and improves case processing.[77]

1. *Early Studies.* Early studies of arbitration panels in the 1970s declared that resolving medical malpractice claims in this manner was a viable alternative.[78] In California, the Hospital Arbitration Project was implemented in eight hospitals with the purposes of disposing of claims quickly, minimizing awards which would otherwise reach juries, and reducing the filing of nonmeritorious claims.[79] The project was found to be successful on these counts. The study determined that where arbitration was used for dispute resolution rather than litigation proceedings, sixty-three percent fewer claims were filed, and twenty-two percent of the filed claims were resolved and closed faster.[80] Furthermore, the hospitals which used arbitration expended fifty-nine percent less in defense costs than did hospitals resolving claims through litigation.[81] One problem, however, was that even though fewer claims were filed in arbitration than in litigation, both forums experienced per annum increases from 1969 through 1975 in the number of claims filed.[82]

2. *The Sayakan and Ladimer Studies.* Subsequent to the California study by Heintz, more evaluations of the effectiveness of medical malpractice arbitration were undertaken. One study which gave a positive review of arbitration was done by Sayakan.[83] Sayakan concluded through empirical data that arbitration, both voluntary and mandatory, meets the demands of reducing the time and costs of resolving medical mal-

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panels, however, when accusations of extreme bias become widespread; they can hinder panel functioning and detract from the mechanism's overall goals.

75. *See* Morris v. Metriyakool, 418 Mich. 423, 344 N.W.2d 736 (1984). The United States Supreme Court has addressed this issue in reference to arbitration clauses in securities disputes. *See* Shearson/Am. Express v. McMahon, 482 U.S. 220, *reh'g denied*, 108 S. Ct. 31.

76. *See* Ladimer, Solomon & Mulvihill, *supra* note 7, at 450.

77. *Id.* at 454.

78. Heintz, *Medical Malpractice Arbitration: A Viable Alternative*, 34 ARB. J. 12 (1979).

79. *Id.* at 13.

80. *Id.* at 18.

81. *Id.*

82. *Id.*

83. *See* Sayakan, *supra* note 27, at 682.

practice disputes.[84] As long as some delays (*e.g.* panel selection) are eliminated, Sayakan maintains that arbitration proceedings are potentially equitable and fair to all parties.[85]

A more comprehensive review of the arbitration of malpractice claims was conducted by Ladimer, Solomon, and Mulvihill in 1981.[86] The authors examined statutory arbitration provisions, as well as private agreements to arbitrate which arose out of subscriber contracts with HMO providers like Kaiser.[87] The overall conclusion was again positive: arbitration can provide a prompt forum for the equitable resolution of physician-patient problems. This is especially true when patients want to settle a difference with a provider, yet still wish to continue treatment with that provider.[88]

Specifically, the authors cited with approval a study which held that "arbitrators are less likely to find for a claimant if there is no liability or if there is doubtful liability in contrast to the sympathies of a jury."[89] They also concurred with the assessment that the arbitration proceedings are economical for the defense.[90] Also, contrary to some perceptions, Ladimer and his colleagues found that arbitration can and does accept large and complex cases, not just simple ones involving smaller injuries. Finally, they concluded that arbitrators are not reluctant to provide large awards when appropriate.[91]

As to the overall effect on the American health care system, the authors declared that resolving medical disputes with arbitration will be most fitting as new forms of health care delivery like HMO's grow in prominence. This is because "the contractual nature of arbitration provides an apt parallel and adjunct to the contractual nature of prepaid medical service plans."[92] For Ladimer, Solomon, and Mulvihill, the key to arbitration's success is making the system appear efficient and fair for all parties, so that on the panels no predisposed biases exist for or against either party.[93] The authors emphasize that the informal nature of the process maintains physician-patient relationships, and the voluntary character of arbitration removes allegations of duress, coercion, or adhesion.[94]

3. *Current Evaluations.* Current assessments of arbitration usage focus on voluntary arbitration provisions, as several states have declared man-

84. *Id.* at 688.
85. *Id.*
86. *See* Ladimer, Solomon & Mulvihill, *supra* note 7.
87. *Id.* at 434.
88. *Id.* at 435.
89. *Id.* at 451.
90. *Id.*
91. *Id.* at 452.
92. *Id.* at 453.
93. *Id.* at 452-54.
94. *Id.* at 454.

datory arbitration to be unconstitutional.[95] This Note examines the systems in Michigan and New York.

Michigan's Medical Malpractice Arbitration Program[96] withstood constitutional challenge in the 1984 Michigan Supreme Court decision of *Morris v. Metriyakool*.[97] The statute essentially requires commercially insured hospitals to offer arbitration as a dispute resolution mechanism to patients.[98] The panels consist of three arbitrators: a physician (preferably from the provider-defendant's specialty), an attorney, and "a person who is neither a doctor, lawyer, nor a representative of a hospital or insurance company."[99] The panels also render written opinions which state the reasoning for finding liability or nonliability, as well as the amount and kind of award given, if any.[100]

Generally, the evaluation of Michigan's program concluded[101] that voluntary binding arbitration is an alternative which decreases the cost of adjudication.[102] Arbitration in Michigan is viewed as handling *less* severe injury claims than those brought in court, thereby discouraging litigation from those plaintiffs who seek high awards yet have only minor injury claims.[103] Thus, for Michigan's health care providers, it would make sense to arbitrate minor claims, and settle the larger claims which have the strongest indication of provider liability. Moreover, the speed and flexibility with which claims are resolved by Michigan panels make arbitration a much preferable alternative to litigation.[104]

In New York, malpractice panels were established in 1975 with the hope of alleviating the state's enormous malpractice problem.[105] At that time, however, panel decisions were only serving as advisory rulings for future juries, and eventually proved to be rather unsuccessful.[106] Consequently, in 1986, amidst the escalation of malpractice insurance premium rates and the increased number of malpractice suits, the New York legislature enacted a provision for the resolution of malpractice disputes by arbitration.[107]

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95. *See* Silas, *supra* note 34. Examples of states where mandatory arbitration has been declared unconstitutional include Florida and Pennsylvania.

96. Michigan Medical Malpractice Arbitration Program, MICH. COMP. LAWS ANN. § 600.5040-5065 (West 1987).

97. 418 Mich. 423, 344 N.W.2d 736 (1984).

98. Powsner & Hamermesh, *Medical Malpractice Crisis the Second Time Around*, 8 J. LEGAL MED. 283, 291 (1987).

99. MICH. COMP. LAWS ANN. § 600.5044(2) (West 1987).

100. *See* Powsner & Hamermesh, *supra* note 98, at 293.

101. *See id.* at 283-304.

102. *Id.* at 303.

103. *Id.* at 301.

104. *Id.* at 298.

105. N.Y. JUD. LAW § 148a (McKinney 1983 & Supp. 1988).

106. Note, *Arbitration and Medical Malpractice*, 11 VT. L. REV. 577, 595 (1986).

107. N.Y. CIV. PRAC. L. & R. §§ 7550-7566 (McKinney 1988).

The New York statute provides that three arbiters, an attorney serving on a full term, and two others selected from a pool of candidates, hear cases as a panel.[108] Unlike Michigan, however, New York's arbitration panel does not include a representative of the medical profession.[109] Furthermore, only claims between providers and enrollees of HMO plans can be arbitrated.[110] Hence, disputes between providers and non-HMO patients are ineligible for arbitration.

Overall, the arbitration panels in New York have not had a significant impact during their brief existence.[111] In deliberating cases, the panels have lacked the necessary expertise without the presence of health care professionals, and since the statute applies to HMO participants only, most New York plaintiffs end up bringing their suits through the largely ineffective malpractice screening panels.[112] Still, the evaluation of New York's statute considers the arbitration concept to be a speedy, less costly, and less traumatic forum for malpractice dispute resolution; perhaps more effective than caps on damage awards and sliding fee scales.[113] For New York health care providers, the current arbitration system appears nonbeneficial, although in time it could become quite useful.[114]

In sum, arbitration provisions, when voluntarily imposed and supported by competent panels, are effective in reducing the volume of claims filed and the overall costs of dispute resolution. Health care providers should thereby benefit from arbitration, provided all parties, including providers, respect panel determinations on liability and damages.

IV. Improving Alternative Dispute Resolution Effectiveness for Health Care Providers

Despite the positive effects which screening panels and arbitration provisions have brought in solving the medical malpractice problem in this country, several jurisdictions are far from reaching the primary goals of reducing the volume of malpractice litigation and decreasing awards given to plaintiffs. The following suggestions encompass the prevailing views on reforming screening panels and arbitration.

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108. *See* Note, *supra* note 106, at 597.
109. *Id.*
110. *Id.* at 596.
111. *Id.* at 598.
112. *Id.* at 599.
113. *Id.* at 601.
114. *Id.*

A. *Suggestions for Screening Panel Reform*

The major problems with screening panels center around biased panels and delays in panel formation and decision-making. When the process takes too long to resolve the dispute or appears inherently unfair, both sides become frustrated, and hence, desire the more familiar litigation process. To address these problems, Carlin has suggested that panels should be monitored for bias, and that panel chairpersons be given broader powers so the hearings can proceed smoothly toward prompt completion.[115] Carlin also advocates choosing panel chairs who are disposition-oriented, so as to strongly impress upon the parties the importance of settling or abandoning claims.[116]

Another important reform which should improve the effectiveness of screening panels is the requirement that panel systems be *mandatory,*[117] and that panel decisions possess some "teeth" in terms of discouraging future litigation.[118] More parties, especially providers, need to be involved in the screening panel process, and once in that process, they must abide by panel determinations when the particular circumstances dictate.[119] If this objective can be achieved, double litigation, which exists in states like Maryland,[120] can be substantially reduced or eliminated. This result would also serve to further reduce the court system's caseload.

B. *Suggestions for Arbitration Reform*

Reforms in arbitration are similarly focused on reducing the biases and delays inherent in many arbitration jurisdictions. The process must be fine-tuned to provide for efficient results, principally through better panel selection procedures, a larger pool of panelists to choose from, and adherence to time guidelines given by the panel chairpersons.[121] Arbitration panels must also be made more accessible to both patients and providers, as is the suggestion for New York.[122] Finally, all parties must be willing to work with one another, and remove any remnants of the adversarial system when resolving their medical malpractice dispute.

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115. *See* P. CARLIN, *supra* note 1, at 41.
116. *Id.* at 40.
117. *Id.* at 39.
118. *See* C. PHILIP & R. FAUST, *supra* note 39, at 40.
119. Circumstances where panel determinations may not provide for complete party adherence are those in which the right to a jury trial is brought into serious question.
120. *See* Silas, *supra* note 34.
121. *See* Sayakan, *supra* note 27, at 689.
122. *See* Note, *supra* note 106, at 599. One possible suggestion to increase the accessibility of arbitration panels in this context would be express provisions for arbitration in HMO contracts. Constitutional questions, however, are potentially implicated when such provisions are enforced.

V. CONCLUSION

For health care providers, the future of alternative dispute resolution in the area of medical malpractice appears bright. In light of the success and positive growth of screening panels and arbitration provisions, more jurisdictions should consider implementing these mechanisms when battling the malpractice problem. Incorporating the necessary reforms into the screening panel and arbitration mechanisms will help further solidify the structure of medical malpractice claim resolution. The end result will be a conventional legal system less burdened by malpractice disputes, which creates for other litigants easier access to the courts of justice.

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