

# Screening Panels: Corrective Surgery or Amputation?

## I. INTRODUCTION

### A. *The Medical Malpractice Problem: Legislative Responses*

Although the existence of a medical malpractice crisis is debated by the legal and medical communities,<sup>1</sup> state legislators have been unable to ignore astronomical increases in claim frequency, jury awards, and medical malpractice insurance premiums.<sup>2</sup> Even though the malpractice problem is attributed in part to the changing environment of the medical practice,<sup>3</sup> numerous statutes have responded with legislation to help alleviate the shortage of insurance coverage for medical care providers and reduce the number of medical claims going to trial.<sup>4</sup> The medical community<sup>5</sup> and the

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1. Compare P. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY* v (1985) (stating the severe medical malpractice crisis of the 1970s is a continuing problem in the 1980s and has taken a recent turn for the worse); TILLINGHAST, NELSON & WARREN, INC., *OHIO MALPRACTICE TRENDS* 2 (May 1987) (a report submitted to the Ohio Senate Health, Human Services, and Aging Committee and prepared for the Health Care Coalition for Professional Liability Reform) (finding no current malpractice crisis in Ohio but the potential for one in the near future if premium increases continue); and ABA COMMITTEE ON MEDICAL PROFESSIONAL LIABILITY, *RECOMMENDATIONS* (1986), noted in *Medical Malpractice: The States Respond*, 9 HEALTH L. VIGIL, at 12 (Feb. 28, 1986) [hereinafter ABA Recommendations] (committee concluded that the tort law system in its present form is working fine and changes to the system are unwarranted).

2. See generally P. DANZON, *supra* note 1, at 2 (documenting the vast increases in insurance premiums, claim frequency, and award size). During 1974-1975, insurance premium rates rose by 500% in some states. In other states, insurance became unavailable. In California, claim frequency and award size increased by 20% per year during the early 1970s, and by 1975, one in three physicians had a malpractice claim pending.

3. In many states the rise in the number of malpractice claims results from the increased incidence of malpractice. See, e.g., PUBLIC CITIZEN, *MEDICAL MALPRACTICE: THE NEED FOR DISCIPLINARY REFORM, NOT TORT REFORM* 5 (Aug. 27, 1985) (report of Health Research Group Report to Ohio Senate Health, Human Services and Aging Committee); *Medical Malpractice, 1986: Hearings Before the Senate Subcommittee on Health*, 116th General Assembly (1986) (testimony of Sidney M. Wolfe, M.D.) (genesis of medical malpractice problem is the quality of health care). Others believe the problem is attributable in part to overly zealous attorneys bringing an excessive number of claims. E.g., P. DANZON, *supra* note 1, at 4. (Danzon states: "such cases exist, but they are far from the whole story.") Inequitable distribution of premiums to health care providers in high risk specialties is cited as still another source of excessive premium rates. NATIONAL INS. CONSUMER ORGANIZATION, *FACT SHEET ON MEDICAL MALPRACTICE INSURANCE, REPORT TO THE OHIO SENATE HEALTH, HUMAN SERVICES, AND AGING COMMITTEE* (1986). Changes in patient and consumer attitudes toward the medical profession and community hospitals may also be a factor. Sakayan, *Arbitration and Screening Panels: Recent Experience and Trends*, 17 FORUM 682, 682-83 (1981)

4. Sakayan, *supra* note 3, at 682-83.

5. Letter from A. Robert Davies, M.D., Treasurer, Ohio Society of Internal Medicine, to Ohio State Senator David Hobson (July 24, 1987) (thanking Senator Hobson for driving Ohio's malpractice legislation to a successful conclusion); Letter from Herbert E. Gillen, Exec. Dir., Ohio State Medical Ass'n, to Ohio State Senator David Hobson (June 16, 1987) (expressing support for Ohio malpractice legislation).

public<sup>6</sup> support such legislation; the legal community has often led the opposition.<sup>7</sup>

While legislative responses have not been uniform, the primary goal of most malpractice statutes was to assure the availability and affordability of malpractice insurance to health care providers. This goal is best understood as a legislative reaction to shocking increases in insurance premiums of up to 500 percent in some states.<sup>8</sup> To insure available and affordable coverage, many states have created joint underwriting associations consisting of private insurance companies which are required to provide affordable coverage for health care providers in order to continue doing business in the state.<sup>9</sup> Other states have created public insurance entities as alternatives to private insurers.<sup>10</sup> In this legislative scheme, health care providers unable to obtain affordable coverage in the private sector can seek insurance coverage through the public provider.<sup>11</sup>

A second goal of the legislation is to reduce the number of claims going to trial. To achieve this, states have enacted statutes requiring the screening of malpractice claims prior to trial by a panel of experts.<sup>12</sup> Other states require that the plaintiff's attorney file an affidavit stating that a physician (or other appropriate expert) has reviewed the allegation and finds probable cause for instituting a malpractice action.<sup>13</sup> Both measures discourage the filing of nonmeritorious claims against health-care providers.<sup>14</sup> Panels may also result in greater settlement of claims prior to trial, thus reducing the number of claims that proceed to trial.<sup>15</sup>

6. When physicians threatened to withdraw services if premium prices continued to rise, the public pressured state legislatures to act. P. DANZON, *supra* note 1, at 2. Premium hikes threatened the existence of public health programs as well. *Hearings Before the House Judiciary Committee on H.B. 327*, 117th Ohio General Assembly (Apr. 22, 1987) (testimony of Dr. Virginia Jones, Chief of the Bureau of Maternal and Child Health, Ohio Dept. of Health).

7. ABA RECOMMENDATIONS, *supra* note 1, at 12.

8. See P. DANZON, *supra* note 1, at 2.

9. *Id.* at 85-87.

10. *Id.*

11. *Id.*

12. Sakayan lists some of the states that, as of 1980, had some kind of mandatory screening statute: Alaska; Arizona; Arkansas; Connecticut; Delaware; Hawaii; Idaho; Indiana; Kansas; Louisiana; Maine; Maryland; Massachusetts; Montana; Nebraska; Nevada; New Hampshire; New Jersey; New Mexico; New York; North Dakota; Pennsylvania; Rhode Island; Tennessee; Virginia; and Wisconsin. See Sakayan, *supra* note 3, at 686 n.17. See also OHIO REV. CODE ANN. § 2711.21 (Anderson 1981 & Supp. 1987).

13. See, e.g., OHIO REV. CODE ANN. § 2307.42(C)(1)(a)(i) (Anderson Supp. 1987).

14. See Sakayan, *supra* note 3, at 686 (mandatory arbitration weeds out unjustified suits); Ohio State Medical Ass'n, Press Release on H.B. 327 (Mar. 17, 1987) (affidavit requirement makes it a little more difficult to file a frivolous suit).

15. See Sakayan, *supra* note 3.

In Hawaii, panel recommendations resulted in a huge percentage of cases settled or dropped. Between 1976 and 1978, New York showed a post-panel settlement rate of 60 percent . . . . In Tennessee, 281 cases out of 376 were either settled,

A third goal of the legislatures has been to streamline the trial process, thereby making the trial less expensive for both parties.<sup>16</sup> For instance, Cook County, Illinois has a unique method of expediting the trial process: the creation of a special malpractice court emphasizing the pretrial stage by limiting time for discovery and tight scheduling of trial dates.<sup>17</sup> This process reduces the time spent in malpractice litigation.<sup>18</sup> Screening panels, however, have not been successful in expediting the trial process and, indeed, frequently result in substantial delays.<sup>19</sup>

This Note considers the efficacy and the constitutionality of screening panels. Emphasis is given to Ohio's experience with screening panels and the reasons the 1987 Ohio Legislature decided to repeal this provision of the Ohio Revised Code.<sup>20</sup> Inherent problems of screening panels are addressed and statutory provisions suggested that could alleviate these problems, thereby making the process work satisfactorily for both parties. It is the position of this author that screening panels are a better tool for preventing frivolous claims than the current Ohio scheme — the affidavit requirement.<sup>21</sup> Furthermore, the screening process provides a less formal forum where the parties can assess the strength of the claim, smoothing the way for realistic settlement discussions.<sup>22</sup>

### B. *Screening Panels Defined*

Screening panels are the creation of state statute.<sup>23</sup> The purpose of the screening panel is to determine whether or not a claim has sufficient merit to proceed to trial.<sup>24</sup> An expert panel, usually consisting of physicians and lawyers, review the validity and the strength of the claim and decide if negligence is present. Screening panels also assist the parties' trial preparation by beginning the discovery process.<sup>25</sup> According

withdrawn, or dismissed. New Jersey's rate of disposition was 88 percent after a panel decision. As a result of Maryland's fifty-seven panel decisions, forty-three claims were resolved.

*Id.* at 687.

16. See P. DANZON, *supra* note 1, at 198.

17. *Id.* at 201-02.

18. *Id.*

19. See Sakayan, *supra* note 3, at 687.

20. See H.B. 327, 117th Ohio General Assembly (1987).

21. See Sakayan, *supra* note 3, and accompanying text.

22. *Id.* at 687. *Contra* OHIO ACADEMY OF TRIAL LAWYERS, POSITION PAPER ON HOUSE BILL 327 MEDICAL MALPRACTICE (Apr. 1987). "Lawyers, insurance companies, physicians and victims of medical malpractice are unwilling to accept anything less than their day in court . . ." *Id.* This position seems particularly attenuated since trial costs are enormous. Plaintiffs going to trial can expect to get 40% of their award, the balance spent on litigation costs. See P. DANZON, *supra* note 1, at 31.

23. See Sakayan, *supra* note 3, at 685.

24. *Id.*

25. See P. DANZON, *supra* note 1, at 202.

to some, the panels are very effective at encouraging pretrial settlement.<sup>26</sup> The following paragraphs describe typical provisions in screening panel statutes.

The selection process is generally provided in the statute. Depending on the statutory scheme, panels may be selected by the parties, by the court if the parties cannot agree,<sup>27</sup> jointly by the court and the parties,<sup>28</sup> or entirely by the court.<sup>29</sup> Statutes may have short deadlines requiring a panel's selection process be completed soon after the filing of a claim.<sup>30</sup> Relatively short time limits are also set for the rendering of a panel's recommendations.<sup>31</sup> Under different statutory schemes, a panel either makes general findings of negligence and assesses damages<sup>32</sup> or makes explicit factual findings. For example, the Alaska statute<sup>33</sup> requires the panel to determine among other things: (1) the plaintiff's disorder, (2) the plaintiff's probable outcome without medical care, and (3) whether the treatment was appropriate.<sup>34</sup>

Panel hearings may be governed by the state procedural rules for arbitration<sup>35</sup> or may have relaxed civil procedural rules.<sup>36</sup> A panel has the power to subpoena witnesses, enforceable by petition to the state trial court.<sup>37</sup> Panel findings are usually admissible at the trial de novo upon motion by either party.<sup>38</sup> Statutes also provide for payment of the arbitrators.<sup>39</sup> Recent amendments to screening panel statutes in some states have provided flexibility in the statute's functioning: parties can agree to waive the screening process,<sup>40</sup> and screening is not required for claims under a specified monetary amount.<sup>41</sup> Additionally, costs of the screening process are allocated to the losing party.<sup>42</sup> In Michigan, for example, if the panel unanimously finds the claim frivolous, the plaintiff must post a bond before going forward with the action.<sup>43</sup>

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26. See Sakayan, *supra* note 3.

27. IND. CODE ANN. § 16-9.5-9-3(a) (Burns 1983).

28. OHIO REV. CODE ANN. § 2711.21 (Anderson Supp. 1987).

29. ALASKA STAT. § 09.55.536(a) (1962).

30. *E.g.*, IND. CODE ANN. § 16-9.5-9-3(a) (Burns 1983).

31. *E.g.*, *id.* at § 16-9.5-9-3.5; ARIZ. REV. STAT. § 12-567G (West Supp. 1988) (panel must render decision 20 days after hearing).

32. *E.g.*, OHIO REV. CODE ANN. § 2711.21(c) (Anderson Supp. 1987); ARIZ. REV. STAT. 12-567G (West Supp. 1988).

33. ALASKA STAT. § 09.55.536 (1962).

34. *Id.* at § 09.55.536(c)(1), (2), (3) (1962).

35. OHIO REV. CODE ANN. § 2711.21(B) (Anderson Supp. 1987).

36. *E.g.*, ARIZ. REV. STAT. § 12-567D (West Supp. 1988) (strict adherence to rules of civil procedure and evidence not required).

37. *E.g.*, OHIO REV. CODE ANN. § 2711.06 (Anderson 1981).

38. *E.g.*, IND. CODE ANN. § 16-9.5-9-9 (Burns 1987); ARIZ. REV. STAT. § 12-567(m) (West Supp. 1988).

39. *E.g.*, OHIO REV. CODE ANN. § 2711.21(A) (Anderson 1981 & Supp. 1987).

40. *E.g.*, IND. CODE ANN. § 16-9.5-9-2(b) (Burns 1987).

41. *E.g.*, *id.* at § 16-9.5-9-2.1.

42. *Id.* at § 16-9.5-9-10(c).

43. MICH. COMP. LAWS ANN. § 600.4915(2) (West 1987).

## II. EARLY OHIO MALPRACTICE LEGISLATION

A. *General Provisions of the 1975 Legislation*

The Ohio General Assembly enacted Amended Substitute House Bill 682 in 1975 responding to both physicians' growing concerns about the availability of liability coverage and the public's concerns about the availability of medical services.<sup>44</sup> The new legislation had several components. It attempted to insure affordable coverage by creating a Joint Underwriting Association to issue and help fund liability coverage for health care providers.<sup>45</sup> The statute sought to reduce claim frequency by shortening the statute of limitations for medical claims to one year against a physician and two years against a hospital.<sup>46</sup> A second provision to reduce claim frequency was the requirement of pretrial mandatory screening of medical malpractice claims.<sup>47</sup> A \$200,000 damage cap for claims not involving death sought to slow the escalating damages,<sup>48</sup> however, at least two lower Ohio courts held the damage cap unconstitutional<sup>49</sup> as violative of due process and equal protection requirements.<sup>50</sup>

The provision for screening panels withstood constitutional scrutiny by the Ohio Supreme Court in *Beatty v. Akron City Hospital*,<sup>51</sup> but was immediately attacked as unworkable by the legal community.<sup>52</sup> Critics of the provision from its birth argued that it delayed the filing of claims and added to the cost of the claim without resolving anything; if the parties really wanted to litigate the claim, they would continue to trial regardless of the panel's findings.<sup>53</sup> Critics of mandatory arbitration ultimately succeeded, and the provision was deleted from the Ohio Revised Code in 1987.<sup>54</sup>

B. *Provisions of the Screening Panel Statute*

Former Ohio Revised Code § 2711.21 mandated the convening of a screening panel upon the filing of a malpractice claim. The panel

44. Ripps, *The Ohio Medical Malpractice Statute: An Analysis*, 4 OHIO N.U.L. REV. 24 (1977).

45. *Id.* at 25.

46. *Id.* at 26-7.

47. *Id.* at 33.

48. *Id.* at 25.

49. *Graley v. Satayatham*, 74 Ohio Op. 2d 316, 321, 343 N.E.2d 832, 839 (C.P. Cuyahoga 1976); *Duren v. Suburban Comm. Hosp.*, 24 Ohio Misc. 2d 25, 29, 482 N.E.2d 1358, 1363 (C.P. Cuyahoga 1985).

50. *Id.*

51. *Beatty v. Akron City Hosp.*, 67 Ohio St. 2d 483, 424 N.E.2d 586 (1981).

52. *See Ripps, supra* note 44, at 35.

53. *Id.*

54. H.B. 327, 117th Ohio General Assembly (1987).

consisted of three arbitrators: one selected by the plaintiff, one by the defendant and one (the chairperson) by the court. All members received reasonable compensation.<sup>55</sup> General arbitration procedural rules were incorporated by reference into the medical malpractice statute.<sup>56</sup>

If the determinations of the panel were rejected by either party, the pleadings had to be amended to aver both the fact that the claim had been submitted to arbitration, and the specific findings of the panel.<sup>57</sup> Either party could admit the decision of the panel into evidence at trial provided the court found that the panel's decision was not clearly erroneous and was in accordance with applicable law. The court also required that the hearing be fair and procedurally correct.<sup>58</sup> The party not offering the panel's decision at trial could subpoena any member of the panel for cross-examination.<sup>59</sup>

### C. Reasons for Repeal

Initially, the defendants' bar was generally supportive of mandatory arbitration, while the plaintiffs' bar was generally opposed to it.<sup>60</sup> By 1987, opposition increased and both the medical and the legal communities favored the repeal of mandatory screening panels. One medical organization called mandatory arbitration a "costly and ineffective system" because the panel proceeding was not binding and the testimony was simply duplicated at trial.<sup>61</sup>

Similarly, the legal community's reaction to the process was negative. The Ohio Academy of Trial Lawyers found various problems in the screening process: panel meetings were difficult to convene because of schedule conflicts of all interested attorneys; the courts selected the chairperson based on economic need, not expertise; the parties abused the process as a discovery tool for subsequent litigation; the parties were forced to try their case twice—duplicating testimony and increasing costs; and panel members selected by the parties voted their interests and did not really provide an objective, expert determination.<sup>62</sup>

The former screening panel provision proved unworkable because of its lack of specificity regarding the mechanics of the arbitration process. The statute provided no time limits for the selection, convening, or decision of the panel. Consequently, delays resulted, and all parties

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55. OHIO REV. CODE ANN. § 2711.21(A) (Anderson 1981 & Supp. 1987).

56. *Id.* at § 2711.21(B) (incorporating §§ 2711.06 - 2711.16).

57. *Id.* at § 2711.21(c).

58. *Id.*

59. *Id.* at § 2711.21(D).

60. Note, *Ohio's Attempts to Halt the Medical Malpractice Crisis: Effective or Meaningless?*, 9 U. DAYTON L. REV. 361, 380 (1984).

61. See OHIO STATE MEDICAL ASS'N, *supra* note 14.

62. See OHIO ACADEMY OF TRIAL LAWYERS, *supra* note 22, at 42-43.

faced with a longer litigation process became disenchanted with screening panels.<sup>63</sup>

The difficulty in convening a panel of busy professionals who all had conflicting schedules was one cause of delays, but the Ohio statute did nothing to limit the length or the frequency of required meetings.<sup>64</sup> The statute did not provide an accessible means to prevent a party's abuse of the process.<sup>65</sup> Complaints to a trial court created additional delay, and as a practical matter would not be brought by the parties for fear of adversely influencing the panel's decision. Moreover, the statute did nothing to provide and prepare experts for panel participation. These omissions in the statute led to its inevitable demise. All of the problems mentioned, however, can be solved by careful drafting, as evidenced by states that have functioning and successful screening panels.<sup>66</sup>

### III. HIGHLIGHTS OF THE 1987 LEGISLATION

The medical community overwhelmingly supported House Bill 327 (H.B. 327) which deleted the mandatory arbitration provision and instituted various provisions in its place. As a result, support for H.B. 327 cannot be regarded as the medical community's definitive rejection of screening panels. Rather, it indicates support for a bill which included a variety of provisions intended to stop premium increases by reducing award size and reducing the number of medical malpractice claims.<sup>67</sup> The medical community's support was focused primarily on the statute of limitations changes, the periodic payment provision, the collateral source rule and the joint and several liability changes — all of which were expected to reduce liability premiums.<sup>68</sup> Even though the purposes of the new legislation parallel those of screening panels, the new provisions are not an effective replacement. The new legislation does not provide any rigorous review of claims, as did screening panels, that will deter frivolous claims. The documentation requirement discussed above is no real barrier to nonmeritorious claims. Another strength of screening panels lay in their encouragement of claim settlement by providing the

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63. See *supra* notes 61-62.

64. OHIO REV. CODE ANN. § 2711.21 (Anderson 1981) (amended 1987)

65. *Id.*

66. *E.g.*, Indiana, a state experiencing great success with its screening process. Burda, *Pretrial Screening Panels: Useful?*, 60 HOSPITALS 35 (Sept. 5, 1986).

67. See OHIO STATE MED. ASS'N, *supra* note 14.

68. OHIO REV. CODE ANN. § 2304.11(4)(A) (Anderson Supp. 1987) (statement of legislative intent). The bill was intended to stabilize the marketplace for medical, dental, optometric and chiropractic professional liability insurance with the concomitant effect of slowing the upward spiral of medical care costs in the state.

party with an expert's assessment of the malpractice claim's validity. Only screening panels provide this unique function; however, this effective settlement tool has been completely discarded. A synopsis of the new legislation follows.

### A. Statute of Limitations

The changes to the statute of limitations on medical malpractice claims<sup>69</sup> were intended to clarify which claims and which professions fell within the special statute of limitations. Derivative claims by parents and relatives for loss of consortium were added to the claims falling within the one year statute. Two groups of medical professionals were added to those covered by the statute of limitations: optometrists and chiropractors.

### B. Periodic Payment of Future Damages

Another provision of H.B. 327 strongly supported by the medical community was the provision for periodic payment of future damages. Procedures for the payment of future damages above \$200,000 periodically, rather than in lump sum payment are set forth in the statute.<sup>70</sup> Either the plaintiff or the defendant can submit a periodic payment plan to the court for approval for damages above \$200,000 (damages below \$200,000 and all attorneys costs must be paid in a lump sum).<sup>71</sup> The court has the authority to approve, disapprove, or alter proposed periodic payment plans,<sup>72</sup> but can only approve plans where the plaintiff is adequately assured of receiving all future payments.<sup>73</sup> To achieve this, the court may approve purchase of an annuity from a highly rated life insurance company.<sup>74</sup> If either party does submit a periodic payment plan, the court must order the first \$200,000 of future damages to be paid in lump sum and the rest of the award paid in some periodic payment scheme.<sup>75</sup>

The periodic payment provision will directly impact premium rates because it will allow insurers to invest the money set aside for future payments, thus reducing their overall costs. Future continuous support for the plaintiff is insured since the plaintiff can't squander his lump sum payment and later require agency support.<sup>76</sup>

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69. OHIO REV. CODE ANN. § 2305.11 (Anderson Supp. 1987).

70. OHIO REV. CODE ANN. § 2323.57 (Anderson Supp. 1987).

71. *Id.* at § 2323.57(C)(2), (E)(2).

72. *Id.* at § 2323.57(D)(1)(d).

73. *Id.* at § 2323.57(E)(1).

74. *Id.* at § 2323.57(E)(1)(a).

75. *Id.* at § 2323.57(C)(1)-(2).

76. *See* OHIO STATE MED. ASS'N, *supra* note 14.



*C. Documentation Required Upon Filing a Malpractice Claim*

Also enacted was a documentation requirement for any medical, dental, optometric, or chiropractic claim.<sup>77</sup> The claimant must file one of three forms of documentation before any state court can exercise jurisdiction over the claim.<sup>78</sup>

Under the first alternative to satisfy the documentation requirement, the claimant's attorney (or the unrepresented claimant) can file an affidavit stating that the affiant has reviewed the claims with a physician (or other appropriate expert) who found reasonable cause for commencement of the action.<sup>79</sup> If the action is based on informed consent, the affidavit must include an additional statement to the effect that the reviewing physician or other expert found that the defendant failed to disclose and discuss material risks inherent in the procedure, that the risk actually occurred, and that the risk caused the claimant's injury.<sup>80</sup>

Under the second alternative, documentation is also satisfied by the claimant's attorney (or unrepresented claimant) by filing an affidavit stating that the affiant was not able to review the claim with an expert and timely commence the action along with the reasons for this inability.<sup>81</sup> A subsequent affidavit with an expert's finding of reasonable cause is required within ninety days of filing the claim.<sup>82</sup>

Finally, a claimant or claimant's attorney can submit an affidavit stating that the claimant or the attorney has submitted a written request to the defendant for the examination of the claimant's records and that the defendant has failed to produce them within sixty days of the request.<sup>83</sup> A subsequent affidavit with an expert opinion of reasonable cause is required within ninety days of receipt of records.<sup>84</sup>

These provisions were intended to discourage the filing of frivolous claims,<sup>85</sup> but are not as effective as screening panels. It will be much easier for a plaintiff to find one physician willing to state that the claim is meritorious than it was to have an objective screening panel make the same conclusion.

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77. OHIO REV. CODE ANN. § 2307.42 (Anderson Supp. 1987).

78. *Id.* at § 2307.42(B).

79. *Id.* at § 2307.42(a)(i).

80. *Id.* at § 2307.43(a)(ii).

81. *Id.* at § 2307.42(b)(i), (ii).

82. *Id.* at § 2307.42(C)(2)(a).

83. *Id.* at § 2307.42(C)(1)(c).

84. *Id.* at § 2307.42(C)(2)(b).

85. *See* OHIO STATE MED. ASS'N, *supra* note 14.

#### D. Disclosure of Collateral Benefits

The medical community enthusiastically supported House Bill ("H.B.") 1, considered concurrently with H.B. 327.<sup>86</sup> One provision of H.B. 1 was the collateral source rule,<sup>87</sup> requiring the plaintiff to disclose to the court collateral benefits received from governmental or private sources. After the court determines that the plaintiff has received or is reasonably certain to receive the benefit within sixty months of judgment, and that there is no right of recoupment of the benefit, the court will reduce the award by the amount of the collateral benefit.<sup>88</sup> The court will increase the award by the amount of the cost of the collateral benefit to the plaintiff (e.g. premiums paid or other costs). However, if previous costs exceed benefits, the court will ignore collateral benefits.<sup>89</sup> This provision was also expected to reduce the size of awards and, consequently, lower premiums.<sup>90</sup>

### IV. THE EFFECTIVENESS OF SCREENING PANELS

In light of Ohio's negative experience with screening panels, the obvious question is whether the panel process is ill-conceived and unworkable. Panels have received mixed reviews from medical and legal commentators alike.

#### A. A Study of Arizona's Screening Panels

An evaluation of the Arizona screening panel process was conducted by the Arizona Medical Association.<sup>91</sup> Though the findings of the study are preliminary because of insufficient data, it suggests that screening panels have both positive and negative consequences. First, on the positive side, a downward trend in the number of malpractice claims filed was noted. This reduction suggests that the panel system is effective in discouraging frivolous medical malpractice claims, especially since frequency of other types of tort claims rose during the same period.<sup>92</sup> An alternative explanation of the downward trend, however, could be that plaintiffs forego small but valid claims because of the tremendous costs of litigating the claim with the panel process. A second trend is the

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86. *Id.*

87. OHIO REV. CODE ANN. § 2317.45 (Anderson Supp. 1987).

88. *Id.* at § 2317.45(B)(2)(c)(ii).

89. *Id.*

90. See OHIO STATE MED. ASS'N, *supra* note 14.

91. Howard, *An Evaluation of Medical Liability Review Panels in Arizona*, 5 STATE CT. J. 19 (1981).

92. *Id.*

rise in the number of claims dismissed with stipulation, indicating a twelve percent increase in cases settled prior to trial, thus furthering one objective of the Arizona statute<sup>93</sup> and screening panels in general.

However, there were negative aspects to the findings as well. On the average, it is estimated that the panel process added \$3,000-4,000 to the cost of litigating a malpractice claim, an expense allocable mostly to expert witness fees.<sup>94</sup> A second problem with the system was the formality and length of the procedure, which served to raise costs. While Arizona's statute has time limits for appointment, convening, and decisions of the panel, in practice these time limits are regularly ignored.<sup>95</sup>

Delay was attributed to two factors. First, it is difficult to convene a group of busy professionals. Second, the hearings are formally conducted and testimony takes up a great deal of time. Most participants agree that live testimony is important to properly evaluate the claim.<sup>96</sup>

The study also determined that the amount and frequency of awards among plaintiffs maintaining claims remained stable,<sup>97</sup> suggesting that for plaintiffs with meritorious claims, the process did not prejudice their award (although the amount they received was necessarily smaller since litigation costs were increased). Also noteworthy is the fact that juries at trial feel free to disagree with panel findings.<sup>98</sup> Further, while a majority of judges believed that the benefits of the process outweighed the burdens,<sup>99</sup> screening has placed additional processing demands on the trial courts, the panel judges, and the court staff.<sup>100</sup>

### B. Intergovernmental Health Policy Project Study

A second study of screening panels was conducted by the Intergovernmental Health Policy Project (IHPP).<sup>101</sup> IHPP concluded that health care providers win eighty percent of all panel decisions, a figure equal to the percentage of cases health care providers win at trial.<sup>102</sup> The study also found that most parties adhere to the panel's findings; therefore a losing party is more willing to settle or drop the claim. Additionally, screening panels dispose of malpractice claims at a faster rate than conventional litigation.<sup>103</sup> The faster disposition of all claims was attributed to the vast increases in some states of settlement or dismissal

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93. *Id.* at 20-21.

94. *Id.* at 24.

95. *Id.*

96. *Id.*

97. *Id.* at 25.

98. *Id.* at 21.

99. *Id.* at 23.

100. *Id.* at 25.

101. See Sakayan, *supra* note 3, at 682, 686.

102. *Id.* at 686-87.

103. *Id.* at 686.

subsequent to the panel's recommendations.<sup>104</sup> However, IHPP also found that the panel process did not meet the goal of prompt resolution of all malpractice claims.<sup>105</sup> Many states with screening panels are experiencing a backlog of claims waiting to go to panel, thus hindering a prompt resolution.<sup>106</sup> The backlog causes include delay in selection because of a shortage of panel participants and scheduling problems.<sup>107</sup>

### C. Indiana's Successful Screening Statute

At least one state, Indiana, has had a very positive experience with its screening process, instituted in 1975 and amended in 1985.<sup>108</sup> The screening process had four desirable results: (1) the use of panels has sped up the resolution of claims by placing time limits on the process; (2) panels help prepare parties for trial by beginning the discovery process; (3) panels reduce the number of nuisance claims; and (4) panels reduce the amounts awarded for those claims not settled.<sup>109</sup>

In summary, since the screening panel process is relatively new, many commentators feel evaluation is not possible until more time has elapsed from the establishment of the process.<sup>110</sup> Many states, as part of their malpractice legislation, have created commissions to evaluate their medical malpractice statutes. More information on the effectiveness of current panels will be forthcoming.<sup>111</sup>

## V. PROVISIONS NECESSARY FOR A SUCCESSFUL STATUTE

Clearly, some states have had better experiences with screening panels than Ohio.<sup>112</sup> Many of Ohio's problems stem from deficiencies in the statute creating the screening panels, not the system itself. Many view the panel process as an effective alternative to conventional litigation. In order to avoid the pitfalls that swallowed the Ohio statute, an explicit statute with a complementary enforcement mechanism is necessary. While the Ohio statute was not held unconstitutional,<sup>113</sup> other similar

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104. *Id.* at 687.

105. *Id.* See also OHIO STATE MEDICAL ASS'N, *supra* note 14.

106. *Id.* at 687-88. In Pennsylvania, only 18 claims have proceeded to panel out of a total of 2,422. In Maryland, the backlog of pending cases grows each year. In 1977-1979, a total of 364 cases were filed; as of May 1, 1981, 134 still awaited a panel hearing.

107. *Id.* at 688.

108. See Burda, *supra* note 66.

109. *Id.*

110. U.S. GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE A FRAMEWORK FOR ACTION 31 (May 1987); *Report of Medical Malpractice Committee*, 20 OHIO ACADEMY OF CIVIL TRIAL ATTY No. 2, at 2 (1985).

111. See OHIO STATE MED. ASS'N, *supra* note 14.

112. See *supra* text accompanying notes 91-100 and 108-11.

113. *Beatty v. Akron City Hosp.*, 67 Ohio St. 2d 483, 487, 424 N.E.2d 586, 595 (1981).

statutes have been.<sup>114</sup> Some of the constitutional weaknesses can likewise be avoided by careful drafting.

### A. *Creation of a Special Malpractice Court*

One problem inherent in any statute that requires participation of a trial level court is a lack of court-responsiveness because of its already bulging docket.<sup>115</sup> Most statutes require the trial court to participate in the panel selection process,<sup>116</sup> to enforce procedural requirements, to supervise discovery if the claim continues beyond screening, and to subsequently try the case. Because prompt attention of the court is essential in order to move the claim through the system, a special malpractice court should be established with jurisdiction over all of these functions, at least for areas with a high volume of malpractice claims. The advantages of a special court include the development of judicial expertise over malpractice matters and a responsive attitude on the part of the court toward all aspects of medical malpractice litigation. Establishment of a special court has been very effective in Cook County, Illinois, where the main focus of the court is accelerating the discovery process by setting short time limits.<sup>117</sup> If the volume of cases in a particular area does not warrant a special malpractice court, an alternative would be to designate a specific judge to respond and to enforce evidentiary and procedural matters in malpractice claims.<sup>118</sup>

### B. *Delay*

Among the biggest problems with the Ohio statute,<sup>119</sup> and common to other states as well,<sup>120</sup> is the tendency for screening to lengthen the total claim processing time. While it is necessarily true that adding a step to filing claims will lengthen the time before disposition, if the process works relatively quickly, for example 180 days total time after selection,<sup>121</sup> the proven benefits of screening panels are worth that delay.<sup>122</sup> Therefore, the primary focus of a statute should be to set forth attainable deadlines for each step of the process. The former Ohio statute had no deadlines whatsoever.<sup>123</sup>

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114. See Sakayan, *supra* note 3, at 686.

115. See Howard, *supra* note 91, at 25.

116. *E.g.*, IND. CODE ANN. § 16-9.5-9-1 (Burns 1983).

117. See P. DANZON, *supra* note 1, at 201-02.

118. See Sakayan, *supra* note 3, at 689.

119. See OHIO ACADEMY OF TRIAL LAWYERS, *supra* note 22, at 42.

120. See Howard, *supra* note 91, at 25.

121. IND. CODE ANN. § 16-9.5-9-3.5(a) (Burns 1983).

122. See Burda, *supra* note 66.

123. OHIO REV. CODE ANN. § 2711.21 (Anderson 1981) (amended 1987).

Examples of workable deadlines can be found in Indiana's Medical Review Panel Statute.<sup>124</sup> Not earlier than twenty days after the filing of the complaint, either party can move for the formation of a panel.<sup>125</sup> The parties are required to select a panel chairperson (an attorney who does not vote) within fifteen days of the request for formation; the court may assist by drawing up a random list for the parties to choose from.<sup>126</sup> Within fifteen days of the selection of the chairperson, the parties must each choose one panelist.<sup>127</sup> The selected panelists then choose a third within fifteen days.<sup>128</sup> Short deadlines are imposed when replacement of any panel member is required.<sup>129</sup> The panel must render an opinion within 180 days of selection of the last panel member.<sup>130</sup>

Unfortunately, even where deadlines are provided by statutes, not all states' panels have adhered to those deadlines.<sup>131</sup> Failure to adhere to the deadlines results from three problems. First, there may be no penalty provisions to encourage compliance. Second, any enforcement falls on an already overburdened court resulting in more delays.<sup>132</sup> Additionally, it is unlikely that the parties will pressure the panel fearing a negative influence on the panel's decision.<sup>133</sup>

Therefore, the solution should have two components. First, the statute should provide penalties for noncompliance with deadlines. Second, as a practical matter, the court would have to enforce the deadlines on its own initiative because the parties probably would not, as previously discussed.<sup>134</sup>

### C. Scheduling Conflicts

Scheduling conflicts plagued Ohio's statute<sup>135</sup> and others elsewhere<sup>136</sup> by inhibiting the panel's ability to convene and causing delays. These conflicts are avoidable by keeping the number of times the panel must convene to an absolute minimum. To accomplish this, and to avoid the delay resulting from testimony,<sup>137</sup> oral testimony should be strictly limited, if not done away with completely. Indiana, for instance, allows

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124. IND. CODE ANN. § 16-9.5-9-1 (Burns 1983).

125. *Id.* at § 16-9.5-9-1(e).

126. *Id.* at § 16-9.5-9-3(a).

127. *Id.* at § 16-9.5-9-3(b)(2).

128. *Id.*

129. *Id.* at § 16-9.5-9-3(b)(3).

130. *Id.* at § 16-9.5-9-3.5(a).

131. *See Sakayan, supra* note 3, at 687-88; *see also Howard, supra* note 91, at 22.

132. *See Howard, supra* note 91, at 25.

133. *Id.*

134. *Id.*

135. OHIO ACADEMY TRIAL LAWYERS, *supra* note 22, at 42.

136. *See Howard, supra* note 91, at 25.

137. *Id.*

only written evidence submitted to the panel members, making it available to all parties.<sup>138</sup> Evidence may consist of records, affidavits, excerpts from treatises, or depositions.<sup>139</sup> Since some feel live testimony is important for adequate evaluation of the claim,<sup>140</sup> a compromise is possible.

First, a statutory provision could require all evidence to be submitted to the panel in written form. After an evaluation period of thirty days, the panel could select and subpoena key witnesses the panel feels they must question in person to reach a decision. An upper limit on the number of live witnesses and the length of testimony completes the process in one or two short sessions.<sup>141</sup> A final meeting would be necessary to make and write up the decision reached.

#### D. *Availability of Experts for Panel Participation*

The difficulty in finding experts, physicians, and attorneys to serve as panel members also causes delays in decisions.<sup>142</sup> One solution is to make compensation adequate to attract volunteers.<sup>143</sup> Indiana (where all voting panel members are physicians) provides a second solution by requiring all licensed health care providers (except health facility administrators) to be available for selection to a panel.<sup>144</sup>

#### E. *Discouraging Small but Valid Claims*

The screening panel's propensity to discourage small, meritorious claims because the added cost of the panels is inhibitive has been severely criticized.<sup>145</sup> Because small awards will not greatly impact premium rates, it is not as important to encourage settlement of these claims. In fact, it could be more expensive for the claims to go through the panel process than allowing swift adjudication.<sup>146</sup> Again, the Indiana statute provides a solution by removing the screening requirement for claims under \$15,000.<sup>147</sup> To avoid frivolous claims, the current Ohio documentation requirement of affidavits would be an adequate replacement for the screening process of small claims.<sup>148</sup>

138. IND. CODE ANN. § 19-9.5-9-3(b)(1) (Burns 1983).

139. *Id.*

140. Howard, *supra* note 91, at 24.

141. Michigan currently limits testimony to 15 minutes unless extraordinary circumstances require additional time. MICH. COMP. LAWS ANN. § 600.4913(3) (West 1987).

142. *See* Sakayan, *supra* note 3, at 688.

143. *Id.*

144. IND. CODE ANN. § 16-9.5-9-3(b)(1) (Burns 1983).

145. *See* Howard, *supra* note 91, at 20.

146. *Id.* at 24. The panel process itself averages between \$3,000 and \$4,000.

147. IND. CODE ANN. § 16-9.5-9-2.1(a) (Burns 1983).

148. OHIO REV. CODE ANN. § 2307.42 (Anderson Supp. 1987).

### F. Reducing Formality of Hearings

Another problem with the screening process experienced in Ohio,<sup>149</sup> and in other states with formal evidentiary requirements,<sup>150</sup> is that the procedure turns into a mini-trial rather than remaining an informal evaluation process.<sup>151</sup> A complete relaxing of evidentiary rules has worked in Indiana.<sup>152</sup> This avoids delays resulting from disputes over evidentiary rulings.<sup>153</sup> Since the panels are made up of experienced professionals, elaborate presentation of the evidence similar to jury trials is regarded as unnecessary.<sup>154</sup> Many of the evidentiary problems will be dispensed with by strictly limiting live testimony as previously discussed. Undoubtedly the panel will function best as an informal process,<sup>155</sup> and the chairperson should strive to achieve this environment.

### G. Selection of the Chairperson

The role of the chairperson can be critical in coordinating meetings of the panel<sup>156</sup> and complying with procedural requirements of the statute, such as time limits.<sup>157</sup> The chairperson is almost always an attorney.<sup>158</sup> In order to both insure the good faith of the chairperson's motives and to free him from decision-making functions, thus enabling him to focus on the panel process, the chairperson could serve exclusively as a coordinator with no vote on the panel.<sup>159</sup> A chairperson should be experienced<sup>160</sup> and familiar with the process. To achieve familiarity, a procedural manual and an orientation to the process would be helpful.<sup>161</sup>

### H. Panel Bias

Plaintiffs in particular may believe that health care providers are inherently biased against malpractice claimants and will vote their professional interests.<sup>162</sup> This fear can be strengthened if the panel members are from the same medical community as the defendant health care providers.<sup>163</sup> Even though members of the medical community reject

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149. See OHIO STATE MED. ASS'N, *supra* note 14.

150. See Howard, *supra* note 91, at 25.

151. *Id.*

152. IND. CODE ANN. § 16-9.5-9-5 (Burns 1983).

153. See Sakayan, *supra* note 3, at 689.

154. See Howard, *supra* note 91, at 24.

155. *Id.*

156. See Sakayan, *supra* note 3, at 689.

157. Murphy, *Pitfalls in Medical Malpractice Panel Practice*, 29 RES GESTAE 178, 179 (1985) (warning attorneys to insure the chairman meets mandatory deadlines).

158. See Sakayan, *supra* note 3, at 689.

159. IND. CODE ANN. § 16-9.5-9-3. (Burns 1983).

160. See Sakayan, *supra* note 3, at 689.

161. *Id.*

162. See P. DANZON, *supra* note 1, at 200.

163. See Howard, *supra* note 91, at 23.



the notion that their decisions are biased toward the position of their peers,<sup>164</sup> certain safeguards should be followed to minimize the potential for bias. Parties can have panel members who are close colleagues of the defendant dismissed from the panel.<sup>165</sup> When practicable, panels could be selected from groups somewhat insulated from the general professional community. For example, a medical educator may be more objective of the malpractice situation than a practicing surgeon. Similarly, medical care providers who have been successfully or unsuccessfully sued for malpractice may be dismissed.

## VI. CONSTITUTIONAL CHALLENGES

There have been several successful constitutional challenges to screening panels.<sup>166</sup> Some types of challenges can be avoided by altering the operation of the panels. Others cannot be. If courts view the screening panel mechanism as usurping the judicial function of decision-making or the jury function of fact-finding, the statute is probably doomed.<sup>167</sup> Most state courts have not found screening panels facially unconstitutional but rather unconstitutional in operation because of undue delays before the panel.<sup>168</sup> The United States Supreme Court has not considered the issue.<sup>169</sup> If panels are racked by substantial delays, there is a risk they may be found unconstitutional in operation.<sup>170</sup> The steps suggested to limit delay should shield the statute from this type of constitutional challenge.

## VII. CONCLUSION

State legislators will continue to seek solutions to the malpractice problem since in most states premium rates and health care costs continue to rise. One tactic is to reduce the number of claims going to trial. Screening panels accomplish this by discouraging frivolous claims and encouraging pretrial settlement. Unfortunately, rather than revamping a poorly drafted statute, the Ohio Legislature chose to discard this process. The new documentation requirement will not be as effective in screening out frivolous claims; there is no other statutory provision that

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164. IND. CODE ANN. § 16-9.5-9-3(b)(3) (Burns 1983).

165. See Sakayan, *supra* note 3, at 686.

166. See, e.g., Murphy, *supra* note 157, at 181. While Indiana's statute withstood constitutional challenge, both the Florida and Pennsylvania Supreme Courts held screening panels unconstitutional because of undue delay during the panel process.

167. See P. DANZON, *supra* note 1, at 189.

168. See Murphy, *supra* note 157, at 181.

169. *Id.*

170. *Id.*

will encourage pretrial settlement. Only screening panels have this characteristic.

Other states enacting new screening panel statutes or amending their current provisions can avoid many of Ohio's problems by careful drafting. If specific time limits for each stage of the screening process are provided and enforced, the problem of delay can be solved. States with well-drafted statutes are now praising screening panels as one step toward halting the rise of liability premiums for health care providers and insuring affordable health care to the public.

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