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# THE MONTANA MEDICAL MALPRACTICE PANEL ACT: ORIGIN, PROCEDURE, AND EFFECT

Karlen J. Moe

## INTRODUCTION

In response to the increasing cost of medical malpractice insurance and to the rising number of malpractice claims, Montana's medical profession lobbied for the protective legislation of the Montana Medical Malpractice Panel Act of 1977 (Panel Act).<sup>1</sup> This comment briefly reviews the events<sup>2</sup> which prompted the creation of the Panel Act and the two Montana Supreme Court cases<sup>3</sup> which construe the Panel Act. The procedural requirements of the Panel Act which require that every claimant file first with the Medical Malpractice Panel before filing in district court, are also discussed. This comment then examines the effectiveness and fairness of the Panel Act.

## I. THE MALPRACTICE INSURANCE PROBLEM

Between 1968 and 1976 the medical malpractice suit transformed from an oddity to a habit. As a result, many physicians found they could not afford to pay their malpractice insurance premiums. More malpractice suits, larger jury verdicts, lower insurance company profits, larger insurance premiums, and fewer insured physicians were symptomatic of the developing nationwide problem of insuring against medical malpractice claims.

Analysts still do not agree as to who caused the insurance premiums to skyrocket; lawyers, clients, physicians, and insurers have all been blamed. According to one analyst,<sup>4</sup> insurers entered the medical malpractice business in the late 1960's and early 1970's

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1. MONT. CODE ANN. §§ 27-6-101 to 704 (1981) [hereinafter cited as Panel Act].

2. Several analysts refer to the sequence of events from 1968 to 1976 in the insurance industry as a "crisis." For more information, see generally Winter, *Medical Malpractice: Will Jumbo Awards Spark Another Insurance Crisis?* 68 A.B.A. J. 1545 (December 1982) [hereinafter cited as Winter]; J. ORLIKOFF, W. FIFER & H. GREELEY, *MALPRACTICE PREVENTION AND LIABILITY CONTROL FOR HOSPITALS* (1981) [hereinafter cited as ORLIKOFF]; and L. LANDER, *DEFECTIVE MEDICINE: RISK, ANGER, AND THE MALPRACTICE CRISIS* (1978) [hereinafter cited as LANDER]. Lander states, rather cogently, that "the malpractice crisis was one of insurance, not of medical practice." *Id.* at 120.

3. In re The Montana Medical Malpractice Panel, \_\_\_ Mont. \_\_\_, \_\_\_ P.2d \_\_\_, 36 St. Rptr. 206 (1979) [hereinafter cited as *In re Panel*]; Linder v. Smith, \_\_\_ Mont. \_\_\_, 629 P.2d 1187 (1981).

4. See generally J. GUNTHER, *THE MALPRACTITIONERS* (1978) [hereinafter cited as GUNTHER].

when the stock market was climbing toward its magical 1000 mark on the Dow Jones Industrial Average. Insuring against medical malpractice was then viewed as a "safe" bonanza—the insurers could collect large premiums, invest them in the rising stock market, and reap huge profits even after deducting the cost of covering malpractice claims.

More insurers entered the bonanza and undercut each other's prices while relying on the mistaken presumption of a constantly rising stock market.<sup>5</sup> Typically, as the present insurer raised its rates, a second insurer offered to maintain the current rate for any new policyholders. Inevitably, the claims paid out by the second insurer exceeded premiums collected. The second insurer raised its rates, and a third insurer tried to enter the market or, as it happened between 1972 and 1976, the insurers simply stopped insuring the high-risk medical profession.

In the midst of the early rush to invest premiums, some insurers apparently forgot<sup>6</sup> that malpractice claims usually are made long after the malpractice occurs. Most insurers used an "occurrence" type of coverage for physicians and hospitals. An "occurrence" policy provides coverage if the policy was in effect at the time the malpractice occurred, regardless of when the malpractice suit is brought. Unlike most types of insurance claims, medical malpractice may not be discovered until a long time after the malpractice occurs. This means an insurer could have to cover claims even though the physician or hospital was no longer insured by the insurer.

Four factors prevented insurers from accurately anticipating the probable cost of malpractice claims brought during the coverage period. First, there were too few reliable statistics from experience to predict the types of malpractice suits most likely filed. Second, any monetary prediction in the early 1970's of the cost of future claims became useless in the wake of spiralling inflation. Third, the time span between the times when the malpractice is made and when the suit is filed, called the "long tail," is very unpredictable. Finally, the stock market's plummet between 1972 and 1976 eradicated any investment cushion the insurers might have had.

The Teledyne, Inc. example illustrates the effect of these four factors on malpractice insurers and the medical profession.<sup>7</sup> Argo-

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5. *Id.* at 191-93.

6. *Id.* at 173.

7. LANDER, *supra* note 2, at 118-19. Lander credits Teledyne, Inc. with triggering the insurance crisis.

naut Insurance Company was acquired by Teledyne in 1969 and became a major medical malpractice insurer. Because the stock market was rising, Teledyne made enough profits in 1973 to offset its underwriting losses with a net operating gain in 1973 of over \$18 million. The next year the amount and number of malpractice awards increased as the insurance "long tail" lashed out, hitting Teledyne with net operating loss of \$105 million.<sup>8</sup> Reacting to this, Teledyne raised its rates. New York rates rose 200% and New York refused to accept this raise. Teledyne, on July 1, 1975, abruptly stopped insuring New York physicians totally and raised rates of those hospitals that it did not drop.

Insurer after insurer followed Teledyne's example, leaving many physicians uninsured when they most needed coverage. Almost all insurers pulled out of the unprofitable malpractice insurance business when the stock market fell nearly 400 points between 1972 and 1974.<sup>9</sup> About this time inflation started its climb upwards and severely diminished the value of all stock market investments. The insurers' earnings fell from a \$1 billion profit in 1972, to \$0 in 1973, to a \$2.6 billion deficit in 1974, and finally to a record \$4.4 billion deficit in 1975.<sup>10</sup>

The insurers' actions affected the medical profession and the malpractice insurance business. For example, hospital accreditation standards were upgraded,<sup>11</sup> and hospitals began to hire risk managers who analyzed the hospitals' liability potential.<sup>12</sup> Insurers switched from "occurrence" policies to "claims made" policies, which provide coverage only for claims made during the policy period regardless of when the malpractice occurred.<sup>13</sup>

Responding to increased premiums and the paucity of malpractice insurers, medical and hospital associations pressed state

8. *Id.* at 119.

9. GUNTHER, *supra* note 4, at 193.

10. S. LAW & S. POLAN, *PAIN & PROFIT: THE POLITICS OF MALPRACTICE* 167 (1978) [hereinafter cited as LAW].

11. A recent publication suggests risk management plans for hospitals concerning physicians and patients. ORLIKOFF, *supra* note 2.

12. According to Orlikoff:

Risk management is the identification, analysis evaluation, and elimination or reduction to the extent of possible risks to hospital patients, visitors, or employees. A risk management program should be a totally integrated program involving hospital and medical staff quality assurance activities, a patient relations (feedback) program and a mechanism for handling incidents, claims, and other insurance and litigation-related tasks.

ORLIKOFF, *supra* note 2, at 32.

13. "Claims made" coverage forces the physician to maintain insurance coverage for claims made against him after his retirement from practice.

legislatures for reform.<sup>14</sup> Legislatures reacted by setting recovery limits on malpractice awards,<sup>15</sup> requiring that claimants use pre-trial screening panels to filter out frivolous claims, encouraging arbitration of small claims to decongest court dockets, and eliminating punitive damages in malpractice cases.

## II. MONTANA'S LEGISLATIVE REACTIONS

In the late 1960's the Montana medical profession sought an alternative to the high-priced litigation which was causing malpractice insurance premiums to climb. The Montana Medical Association and the Montana Bar Association joined forces and in 1968 drafted their proposal<sup>16</sup> for voluntary malpractice screening panels. Under the 1968 proposal, a claimant would get an expert medical evaluation of the claim by filing with the panel. Unlike the present plan, the 1968 proposal was permissive, not mandatory, and the claimant, not the physicians, paid the panel's costs.<sup>17</sup>

The effectiveness of the 1968 proposal depended upon the voluntary cooperation of the claimant: the claimant would have to choose to file first with the panel rather than go to court, and the claimant would have to opt against filing in court after an unfavorable panel decision unless there existed compelling reasons. The voluntary panels did not lower appreciably the insurance premiums during the five years of the panel's existence.<sup>18</sup> This ineffectiveness and the sharp increases in the number of claims made, together with the rising damages awards, caused the state legislature to look again at Montana's medical malpractice insurance program.

### A. *The Panel Act*

Early in 1976 an eight-member committee recommended to the legislature that all medical malpractice claims should be sub-

14. LANDER, *supra* note 2, at 143, states:

In the two years 1975 and 1976 the legislatures of forty-nine states plus Puerto Rico and the Virgin Islands responded to the malpractice crisis by enacting over 250 pieces of legislation that could be advertised as constituting [malpractice reform.] (Only Montana and the District of Columbia stayed off the bandwagon.)

15. WINTER, *supra* note 2, at 1546, states that Indiana's \$500,000 limitation on recovery in malpractice cases is the most protective statute so far, and the statute was declared constitutional by the Indiana Supreme Court in 1980.

16. MONT. MEDICAL ASS'N. & MONT. BAR ASS'N., JOINT MEDICAL-LEGAL PLAN FOR SCREENING CLAIMS OF MEDICAL PROFESSIONAL LIABILITY, (1969) (amended 1973).

17. *Id.* at 3.

18. Note, *The Montana Plan for Screening Medical Malpractice Claims*, 36 MONT. L. REV. 321, 327 (1975).

mitted to a mandatory pre-trial screening panel before the claims were filed in court.<sup>19</sup> The legislature codified this suggestion in the Panel Act.<sup>20</sup>

The committee also suggested using voluntary arbitration for malpractice claims.<sup>21</sup> Arbitration has been an effective substitution for trial in complex areas such as labor negotiations and commercial transaction disputes.<sup>22</sup> Arbitration reduces resolution time, does not adhere strictly to the rules of evidence, binds the parties under contract, and is not a matter of public record.<sup>23</sup> Arbitration can be used to resolve technical negligence issues; one authority<sup>24</sup> contends arbitration would best suit small claims. Arbitration remains a viable alternative to trial and is provided for by statute,<sup>25</sup> but there is no conclusive evidence that arbitration is used widely for medical malpractice claims. The Panel Act, however, remains the primary resolution technique for encouraging settlements.<sup>26</sup>

Under the Panel Act, a claimant begins a malpractice claim by filing an application with the panel director<sup>27</sup> and by sending to the director permission to release all pertinent medical records. A copy of the application is forwarded to the defendant who must also release medical records relating to the case. The director chooses three attorneys and three physicians for the panel.<sup>28</sup> A party may disqualify up to three nominees per application by filing an affidavit contesting the nominees' impartiality.

Each hearing is informal, and no official transcript of the hearing is recorded. The panel deliberates in secret and decides by a majority vote of those members present throughout the hearing. The decision is inadmissible at a later court proceeding, but a wit-

19. MONT. LEGISLATIVE COUNCIL, *MEDICAL MALPRACTICE* (1976) [hereinafter cited as 1976 Report] at 31-32. This was an interim study by the Select Committee on Medical Malpractice.

20. The Panel Act, *supra* note 1.

21. 1976 Report, *supra* note 19, at 31.

22. *LAW*, *supra* note 10, at 128.

23. Many physicians prefer arbitration because of its privacy and because they believe that arbitration awards are smaller than jury verdicts. *LANDER*, *supra* note 2, at 159.

24. R. GOTS, *THE TRUTH ABOUT MEDICAL MALPRACTICE: THE PATIENT'S RIGHTS/THE DOCTOR'S RIGHTS* (1975). The author recommends that arbitration, if used, should apply only to small claims of under \$10,000. *Id.* at 208.

25. MONT. CODE ANN. § 27-6-105 (1981).

26. *LAW*, *supra* note 14, at 128, explains that even if the panel is not successful in reaching a settlement, the panel narrows and defines the issues for trial.

27. Applications should be directed to the Panel Director, whose office is currently located at 2021 11th Avenue, Helena, Montana 59601.

28. The physicians selected must be licensed to practice in the same specialty as the physician involved. If a hospital is named, then one of the physicians' positions will be held by a representative of a similar hospital.

ness' testimony in the hearing can be used to impeach that witness in a later court proceeding.<sup>29</sup>

Panel members must decide if there is "(1) substantial evidence that the acts complained of occurred and that they constitute malpractice and (2) a reasonable medical probability that the patient was injured thereby."<sup>30</sup> A record of the decision and a brief description of the claim are filed with the panel director, and the decision is served on the claimant and defendant by certified mail. The statute of limitations for filing a medical malpractice claim<sup>31</sup> is tolled from the date the director receives the claimant's application until the panel serves its decision on the claimant.

### B. Challenges to the Panel Act

Only two cases construing the Panel Act have been decided by the Montana Supreme Court. The first case, *In re The Montana Medical Malpractice Panel*,<sup>32</sup> challenged the Panel Act's funding, and the second case, *Linder v. Smith*,<sup>33</sup> challenged the Panel Act's constitutionality.

In *In re The Montana Medical Malpractice Panel*, decided in 1979, the panel requested the supreme court to approve a Panel Act cost allocation of forty percent to the hospitals and sixty percent to physicians. Under the panel's proposal, the Montana Hospital Association (MHA) would be responsible for collecting the hospitals' share. The MHA contested this proposal because, unlike the physicians, the hospitals were not required to belong to the state professional association and the MHA therefore could not regulate them. The MHA also contended that the forty-sixty split did not accurately reflect the proportionate costs of malpractice defense.<sup>34</sup> The supreme court, in an original proceeding, denied the panel's request and found the proposal unworkable and arbitrary. Because of this decision, the Panel Act is now funded entirely by those physicians licensed to practice in Montana.

In *Linder*, the claimant (Linder) did not file his claim with the panel director. Instead he filed directly in state district court and claimed that the Panel Act was unconstitutional primarily on three grounds. First, Linder claimed that mandatory submission of his claim to the panel interfered with his right to a jury trial. The su-

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29. See *infra* text at notes 47-49.

30. MONT. CODE ANN. § 27-6-602 (1981).

31. MONT. CODE ANN. § 27-2-205 (1981).

32. *In re Panel*, *supra* note 3.

33. *Linder*, \_\_\_ Mont. \_\_\_, 629 P.2d at 1187.

34. *In re Panel*, *supra* note 3, at 209.

preme court asserted that the Panel Act was an effective method of reducing the number of frivolous claims and likened the pre-trial screening panel to the pre-trial conference.<sup>35</sup> The supreme court held that the panel was a permissible interference with the right to a jury trial and was not a denial of that right.

Second, Linder claimed that the costs and delays of the panel imposed a substantial and irrational burden on a claimant. The supreme court stated that in this particular case access to court was not an independent fundamental right,<sup>36</sup> that there was a rational basis for the delay caused by the panel, and that the delay was permissible. The court-appointed Master, acting as the supreme court's fact-finder, determined that a malpractice crisis exists in Montana.<sup>37</sup> Finding the Panel Act to be a reasonable response to the crisis, the court also found "no impermissible burden on access."<sup>38</sup>

Finally, Linder contended that a panel is inherently biased against the claimant because a panel contains medical personnel.<sup>39</sup> The supreme court noted, however, that a panel's decision is not admissible as evidence in a later trial and that a decision has a limited effect on the claimant.<sup>40</sup> The court also ruled that Linder did not adequately show bias which would violate due process.

The supreme court did find that the first sentence of Montana Code Annotated section 27-6-704(2) denied a litigant the right to impeach a witness on the witness' sworn testimony and severed this sentence after declaring the Panel Act constitutional.<sup>41</sup> Under the Panel Act, each witness testifying to the panel is sworn under oath.<sup>42</sup> The first sentence of subsection two reads as follows: "(2) No statement made by any person during a hearing before the panel can be used as impeaching evidence in court."<sup>43</sup> A party would not be given a fair and full hearing if there were no opportunity to impeach a sworn statement. This sentence was properly deleted from the Panel Act.

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35. *Linder*, \_\_\_ Mont. \_\_\_, 629 P.2d at 1189.

36. *Id.* at 1190.

37. The Master determined that a medical malpractice crisis existed, noting that Montana ranked number seventeen on a list of states with the highest insurance premium rates. *Id.* at 1190.

38. *Id.* at 1191.

39. LAW, *supra* note 10, at 126, agrees.

40. *Linder*, \_\_\_ Mont. \_\_\_, 629 P.2d at 1192.

41. *Id.* at 1195.

42. MONT. CODE ANN. § 27-6-502(2) (1981).

43. MONT. CODE ANN. § 27-6-704(2) (1981).



### C. *The Panel Act's Effect*

The Panel Act solves Montana's medical malpractice insurance problem at the expense of creating another. Research indicates that the number of malpractice claims going to trial has been drastically reduced, but the Panel Act unfairly lays its heavy financial burden solely on Montana's physicians.

The Panel Act's main purpose—discouraging frivolous claims—has not necessarily been met just because the bare number of cases going to court has been drastically reduced. A great injustice occurs if an adverse panel conclusion discourages a claimant from pursuing a meritorious claim in court. Statistics from a 1983 report published by the Montana Medical Malpractice Panel<sup>44</sup> reveal that the Panel Act may act as a barrier, not as a sieve, and may discourage all claims, not just frivolous (as interpreted by a panel) claims. According to the 1983 report, only *one* claim has even been tried of all the claims disposed of by the panel from 1977 to 1982,<sup>45</sup> representing a drop of 88%.<sup>46</sup> Of the 181 claims filed with the panel director,<sup>47</sup> claimants received a favorable decision from the panel 23% to 25% of the time, compared to a national average of 30%.<sup>48</sup> The Montana Supreme Court in *Linder* specifically said that the Panel Act does not impose an impermissible burden on the judicial process,<sup>49</sup> but the new data from the 1983 report justify a reconsideration of this possibility.

The full cost of the Panel Act, according to the 1983 report, is borne by the "health care providers."<sup>50</sup> The report fails to reveal, however, that since *Linder* the entire cost is paid only by physicians. The average cost per claim is \$2,469 and the fixed (minimum) annual cost is \$52,441.<sup>51</sup> These costs are not fairly apportioned among those benefitting from the Panel Act. Because of a panel's decision, the claimant gets a free expert medical evaluation of the claim. The defendant gets a free, complete preview of the claimant's case. All of the Montana physicians get stuck with the

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44. MONT. MEDICAL MALPRACTICE PANEL, SUMMARY OF SURVEY OF CLAIMS BEFORE THE MONTANA MEDICAL MALPRACTICE PANEL THROUGH 1982 (1983) [hereinafter cited as 1983 Report].

45. *Id.* at 9.

46. *Id.* at 7.

47. *Id.* at 2.

48. *Id.* at 7.

49. *Linder*, \_\_\_ Mont. \_\_\_, 629 P.2d at 1192.

50. 1983 Report, *supra* note 44, at 8.

51. *Id.*

bill, although most have never been sued for malpractice.<sup>52</sup> The Montana Supreme Court specifically requested that the state legislature address this very problem;<sup>53</sup> nothing, however, has been done.

#### SUMMARY

As a reaction to the malpractice insurance problems of 1968-1976, Montana adopted the Panel Act and the Montana Supreme Court has decided two cases construing the Panel Act. The Panel Act has effectively reduced the number of malpractice claims but unfairly requires that Montana physicians alone pay the Panel Act's costs.

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52. A more equitable solution would be to allocate a portion of the panel's costs to each claimant and defendant involved in the particular malpractice suit. This would lessen the burden on physicians when hospitals or nursing homes are named as defendants.

53. The Montana Supreme Court suggested the legislature reconsider the Panel Act's cost allocation in *In re Panel*, *supra* note 3, at 209.

