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## THE MONTANA PLAN FOR SCREENING MEDICAL MALPRACTICE CLAIMS

G. Geoffrey Gibbs

“Malpractice . . . means bad or unskillful practice resulting in injury to the patient and compromises all acts and omissions of a physician or surgeon as such to a patient as such, which may make the physician or surgeon either civilly or criminally liable.”<sup>1</sup>

### INTRODUCTION

Until the last decade, claims against physicians for medical malpractice were rarely instituted in Montana or elsewhere. In 1965, however, over 31,000 physicians in the United States were burdened by a malpractice claim or suit. Currently between 10,000 and 18,000 new claims for medical malpractice are filed each year,<sup>2</sup> and the total number of claims in the United States is increasing at the rate of at least ten per cent per year.<sup>3</sup>

Montana has not seen the great number of claims for malpractice that have arisen in more populous areas, but the Montana physician is sharing in the impact. The cost of professional medical liability insurance coverage on a nationwide average has risen 949.2% between 1962 and 1972.<sup>4</sup> The Montana surgeon, for example, will have to pay 129% more in premiums for the same insurance coverage on January 1 of this year, as compared with January 16, 1974.<sup>5</sup> This note reviews the effectiveness of the current Montana approach to the growing number of malpractice claims and discusses other alternatives which should be considered in seeking further solutions to a problem which presents an increasing burden on physicians, lawyers and the courts alike.

### THE MEDICAL LEGAL SCREENING PANEL

The Montana Medical Association began a search in 1968 for alternatives to litigation for malpractice claims. The Association chose litigation as its target because the bulk of the total amount paid by physicians in premiums is used in the litigation process.

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1. *Bakewell v. Kahle*, 125 Mont. 89, 232 P.2d 127, 129 (1951).

2. REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, Department of Health, Education & Welfare, Publication No. (05) 73-88, at 6 [hereinafter referred to as H.E.W. REPORT].

3. H.E.W. REPORT, *supra* note 2 at 7, Figure 1.

4. H.E.W. REPORT, *supra* note 2 at 13.

5. Interview with Glen R. Henckel, of Toole & Easter Insurance Co., Missoula, Montana (hereinafter referred to as Henckel Interview). A complete summary of that interview is contained in the Appendix.

Recent figures indicate that legal fees and costs account for at least half of the premiums paid by physicians and hospitals. The insurance companies take about 25 per cent, and the injured patients receive less than 25 per cent of the total amount of money paid for insurance premiums.<sup>6</sup>

The Medical Association chose the voluntary screening panel approach as the most practical alternative to litigation in Montana. The panel is composed of an equal number of physicians and attorneys who sit in review of claims voluntarily submitted. This plan was patterned after the screening panels used successfully in Pima County, Arizona, and in New Mexico. The former was started in 1957 and the latter in 1963.<sup>7</sup> New Mexico found that with the adoption of their voluntary screening panel the state dropped from its position as the seventh-ranked state in number of malpractice suits filed to forty-eighth.<sup>8</sup>

The Montana medical-legal screening panel for claims of medical malpractice was instituted in 1970 with a two-fold purpose:

1. to prevent where possible the filing in court of actions against physicians and their employees for professional malpractice in situations where the facts do not permit at least a reasonable inference of malpractice, and
2. to make possible the fair and equitable disposition of such claims against physicians as are, or reasonably may be, well founded.<sup>9</sup>

The Montana Plan is based on voluntary submission of a claim by a claimant's attorney prior to filing the action in court. The defendant must also submit to participation in the screening process.

To file a claim for hearing, the claimant's attorney submits a request in writing with the 50 dollar filing fee to the Montana Medical Association stating in reasonable detail the facts surrounding the alleged professional negligence. The request must also contain a statement authorizing the panel to obtain access to all medical and hospital records and an agreement that all deliberations and discussions of the panel, and witnesses appearing before it, shall be privileged as to any other person.

Upon such submission, the medical chairman of the panel will

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6. AMERICAN MEDICAL NEWS, *Malpractice Outlook Bleak*, November 4, 1974 at 18.

7. A. Fulton, *The Medicolegal Screening Panel: An Evaluation of Montana's Experience*, Jan. 6, 1973 (unpublished).

8. *Id.*

9. JOINT MEDICAL-LEGAL PLAN FOR SCREENING CLAIMS OF MEDICAL PROFESSIONAL LIABILITY, adopted by the Montana Medical Association and the Montana Bar Association in June 1969, as amended through July, 1973, at 1 (hereinafter referred to as MONTANA PLAN). This handbook is published by the State Publishing Co., Helena, Mt., and is available upon request from the Montana Medical Association, Helena, Montana.

furnish the claimant's attorney with the names of three specialists in the appropriate field of medicine so that the claimant may select one with whom to discuss his case without any requirement for compensation.

At the panel hearing, the claimant or his attorney will begin by stating the facts, either in narrative form or by question and answer. The claimant or his witnesses are then subject to cross-examination by the defendant physician or his counsel. The physician or his counsel may then present any defense, subject to the same rules as the claimant. There is a provision in the panel's procedure for appointment of a "Panel Expert", and if one is appointed by the medical and legal chairmen, he will follow the claimant and the defendant. After presenting his opinion, he is subject to examination by either counsel.

The panel members, after the entire presentation, will take up in private the first of two questions: "Is there any substantial evidence of malpractice?" If the majority vote is in the negative, the matter shall be closed. If, by majority vote, the panel members find that there is substantial evidence of malpractice, they then proceed to answer by majority vote the question "Do the facts tend to show reasonable medical probability that the claimant was injured thereby?"

The panel then reports its findings to the parties. It does not attempt to measure damages. If the case is thereafter filed in court, after affirmative answers by the panel to the two preceding questions, the Medical Chairman will assist the claimant's attorney in obtaining whatever expert medical testimony he feels is necessary. If the answer to either of the two questions is negative, the claimant, by his subscription to the plan, has agreed that he will not thereafter file the claim in court unless there exist compelling reasons that in good faith mandate such action.<sup>10</sup>

### EVALUATION

Though New Mexico experienced a distinct drop in the number of cases filed in court, in other states using a voluntary medical-legal screening panel, especially California, the approach has not been effective.<sup>11</sup>

Three general categories of data are used to measure the effectiveness of alternatives to malpractice litigation.<sup>12</sup> *The time to trial*

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10. MONTANA PLAN, *supra* note 9 at 2-9.

11. Assembly Select Committee on Medical Malpractice, State of California, *Preliminary Report*, June, 1974 at 43 and 66.

12. Comment, *The Medical Malpractice Mediation Panel in the First Judicial Department of New York: An Alternative to Litigation*, 2 HOFSTRA UNIV. L. REV. 261, 265 (1974); A.

or ultimate solution of the case is the first criterion, and is one that affects not only insurance actuarial tabulation but has tremendous impact on an injured plaintiff awaiting compensation.<sup>13</sup>

The *conspiracy of silence*, or the reluctance of one physician to testify against another, has proved to be a major obstacle for plaintiffs and their attorneys and the elimination of this problem is another stated goal of the Montana Plan.<sup>14</sup>

The *reduction of professional liability insurance rates* was the third of the primary forces moving Montana physicians, and those in other states, to seek alternatives to the trial litigation process. A reduction in these rates would be an indication of the success of the screening panel.<sup>15</sup>

### A. Time to Trial

One of the goals of the Montana Plan was to reduce the number of claims that were filed in court. For two and one half years preceding the screening panel's operation, eighty complaints of malpractice were reported to Montana insurance carriers. Fifty-seven of these cases were filed in court.

During the period of January, 1970, to June, 1972, after the panel began its operation, seventy-five complaints were reported, but only twenty-six were filed in court. This represented a reduction of fifty-four per cent. During the same time, twenty-eight cases were filed with the screening panel.<sup>16</sup>

Since June of 1972, there have been ninety-nine claims reported to the four major insurance carriers.<sup>17</sup> But during that time there has also been a noticeable decline in the number of cases filed with the panel and those actually heard before it. At the last western district panel meeting prior to March 1, 1975, four cases had been filed and only one was actually heard.<sup>18</sup> The panel for the eastern district in Montana has not met in over a year.<sup>19</sup> Though the number of cases filed in all district courts in Montana has not been tabulated, there have been at least thirteen cases filed in Yellowstone County alone

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Fulton, *supra* note 7; H.E.W. REPORT, *supra* note 2 at 34-38.

13. H.E.W. REPORT, *supra* note 2 at 34, 40.

14. H.E.W. REPORT, *supra* note 2 at 36; MONTANA PLAN, *supra* note 9 at 1.

15. A. Fulton, *supra* note 7 at 8.

16. *Id.* at 6.

17. Henckel Interview, *supra* note 5.

18. This information was repeated in separate interviews with Bryan Zins, Executive Director of the Montana Medical Assoc., Mr. Randall Swanberg, Esq., Legal Chairman for the Eastern District of the Montana Panel, Dr. John Pfaff, Panel member for the Eastern District, and Dr. John Fulton, Medical Chairman for the Western District of the Montana Panel.

19. *Id.*

during this two and one-half year period.<sup>20</sup>

A possible reason for part of this decline in screening panel use is that one major carrier reportedly refuses to allow its insureds to participate.<sup>21</sup> Other companies are dissatisfied with the panel, seeing it as another discovery device for a plaintiff's attorney.<sup>22</sup> Some plaintiffs have been forced to file in court, and forego use of the screening panel because of the long interval between panel appearances and the running of the statute of limitations.

Certain limited conclusions can be drawn from these facts. There was an initial drop in the number of cases filed in court directly attributable to the operation of the screening panel. But beyond this initial period, panel use has decreased. The time to trial or settlement may have actually increased for panel participants because of the lengthy waiting period between meetings of the screening panel.

### B. Conspiracy of Silence

The reluctance of one physician to testify against another has caused a great deal of resentment within the legal community and among the general public as well. The Secretary's Commission on Medical Malpractice found the underlying reasons for this reluctance to testify to be the following:

1. The reluctance to suffer loss of time and income from practice that may be involved in a court appearance;
2. The inability to provide care to patients while away in court;
3. The fear and resentment of physicians regarding cross-examination under the adversary legal system;
4. The natural reluctance to injure friends and fellow craftsmen, coupled with the feeling that "there but for the grace of God go I"; and
5. The common belief that . . . most malpractice claims are without sound basis.<sup>23</sup>

The Secretary's Commission found that the waning importance of the locality rule<sup>24</sup> in malpractice actions, the increasing accept-

20. Information obtained from the records of the Clerk of the District Court, Yellowstone County, Billings, Montana.

21. Henckel Interview, *supra* note 5, referring to St. Paul Insurance Company.

22. Henckel Interview, *supra* note 5.

23. H.E.W. REPORT, *supra* note 2 at 36, 37.

24. The locality rule is a guideline used to establish a standard of care for physicians. The duty of a physician under such a rule is to exercise such reasonable care and skill as is usually used by a doctor in good standing in the community in which he resides. *Negaard v. Fedas*, 152 Mont. 47,446 P.2d 436 (1968). Though many jurisdictions are abandoning the locality rule as a standard of care, the Montana supreme court refused to do so even when both parties to an appeal argued for such a ruling and adoption of a broader, national

ance of national, rather than local, standards of care, as well as a more cooperative and conscientious response from individual physicians and medical societies have combined to make the needed expert testimony more generally available.<sup>25</sup>

The Montana Plan was designed specifically to provide the plaintiff's attorney with medical expertise before the panel appearance upon which he could draw to adequately judge the merits of his case. If the panel enters a favorable verdict for the plaintiff, the Medical Association will assist the attorney in procuring sufficient expert testimony. For this advantage, the plaintiff must agree by his use of the panel not to file a case after a negative verdict unless there are compelling reasons to do so.<sup>26</sup>

For these reasons, expert medical testimony is becoming more available to the medical malpractice claimant due to use of the screening panel and to a generally more conscientious response on the part of physicians.

### C. Professional Liability Insurance Rates

The meteoric rise in malpractice insurance premiums was one of the forces motivating the Montana Medical Association to seek alternatives such as the screening panel. It was hoped that by reducing the number of cases that were filed in court, the associated legal fees and costs would also decrease in proportion. This would enable insurance carriers to reduce rates.

The rates are generally computed by the Insurance Services Office [hereinafter referred to as the I.S.O.], which is an independent rating organization used by member insurance companies.<sup>27</sup> In computing malpractice insurance rates, the I.S.O. is most troubled by the protracted period of time that a typical malpractice claim takes to settle. It generally takes more than five years before an average cost per claim can be computed.<sup>28</sup> The reasons generally given for this delay are court congestion, the lengthy time for preparation of a malpractice case, and the natural tendency to delay as a stratagem.<sup>29</sup> The actuarial computation of rates is further complicated by the dramatic increase in both the number of claims and the size of settlements in the past decade.<sup>30</sup>

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standard of care. *Collins v. Itoh*, 160 Mont. 463, 503 P.2d 36 (1972). A decision abandoning the locality rule is *Pederson v. Dumouchel*, 72 Wash.2d 73, 431 P.2d 973, 977 (1967). See also Recent Developments, 14 STANFORD LAW REVIEW 884 (1967).

25. H.E.W. REPORT, *supra* note 2 at 36-37.

26. MONTANA PLAN, *supra* note 9.

27. H.E.W. REPORT, *supra* note 2 at 41.

28. *Id.* at 42.

29. *Id.*

30. *Id.* at 42 and 43.

Even though the screening panel has been operating for five years, the insurance rates for Montana physicians continue to increase both in dollar amounts for premiums and in the annual percentage rate of increase.

A specialist in Montana in what was formerly referred to as a Class 5 risk category, typically an anesthesiologist or orthopedic surgeon, will pay \$7133 per year under a group plan offered by the Montana Medical Association. This represents an increase of 129% in one year. Physicians not utilizing this group plan will pay a higher premium for the same coverage, but the rate of increase is the same.<sup>31</sup>

Even though insurance rates do not respond immediately to lower costs to the company, and although it generally takes more than five years before the average cost per claim can be computed, some reflection of what success the screening panel has had in reducing claims filed in court should already have been reflected in Montana insurance rates. The Montana claim does not face the amount of court congestion which claims in other areas experience, and therefore the time to settlement is less than the national average.<sup>32</sup>

#### ANOTHER PLAN

The First Judicial District of New York has implemented a mandatory judicial screening panel which is composed of a judicial officer, a medical specialist, and a legal specialist.<sup>33</sup> Whereas panel members in Montana are appointed for a three year term, the medical and legal specialists in the New York plan are drawn from a pool of such specialists provided by the Medical Society and the Bar Association. This judicial screening panel is combined with a plan for mandatory arbitration of claims if the recovery sought is less than \$4000.

The New York mediation plan also utilizes a "confidential figure" scheme, in which the judge, dismissing the amount demanded in the complaint as meaningless, requires that each side submit to him, in confidence, the figure at which they would like to settle and another figure below or above which they will not settle. The judicial officer then attempts to encourage a settlement within the range so established.<sup>34</sup>

The mediation panel in New York's First Judicial District has

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31. Henckel Interview, *supra* note 5; See Appendix.

32. See discussion, *supra* note 20.

33. Comment, *The Medical Malpractice Mediation Panel in the First Judicial Department of New York*, *supra* note 12 at 261.

34. *Id.*



been handling over thirty-two cases per month and has been tremendously successful in reducing the backlog of malpractice cases. Of the cases presented, over forty-two percent are settled after the appearance before the panel, and about four per cent are discontinued. The percentage of cases settled after an appearance before the panel is increasing as the newer cases are heard and the panel disposes of the older cases.<sup>35</sup>

The New York plan has significantly decreased the time from injury to trial or settlement, and in the case of claims for \$4000 or less, provides an arbitration scheme completely outside the district court level. Because of the mandatory appearance before the panel for all cases in the district involving medical malpractice, the judicial officer has greater power to encourage settlement and a much greater percentage of the total number of claims is being settled in New York than under the Montana voluntary screening panel approach.<sup>36</sup> The small membership of the panel makes it more efficient in that it meets more often. If used in Montana, this approach would decrease the cost involved in preparation for panel meetings and travel costs for the members.

#### CONCLUSIONS AND RECOMMENDATIONS

Many other approaches are currently being tried to eliminate the trial process in the area of medical malpractice. Some states are using a modified New York approach, with a binding option not to pursue a claim to trial if the screening panel decides against the claimant.<sup>37</sup> Areas of other states are using a pure arbitration scheme.<sup>38</sup> At least one foreign country has moved to a no-fault insurance system for injuries resulting from medical treatment,<sup>39</sup> and doctors in another country have instituted defense leagues to sue for defamation against a person bringing a frivolous claim of medical malpractice.<sup>40</sup>

In all of these areas there has been a continuing effort to keep track of the entire area and review the success of each program.<sup>41</sup>

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35. *Id.* at 276.

36. *Id.*; A. Fulton, *supra* note 7 at 6.

37. Comment, *The Medical Malpractice Mediation Panel in the First Judicial Department of New York*, *supra* note 12 at 283; *Grove v. Seltzer*, 56 N.J. 321, 266 A.2d 301 (1970).

38. A number of areas in California are utilizing a pure arbitration scheme, either on an experimental or permanent basis. A listing of these areas, and a summary of their activities may be found in the Assembly Select Committee on Medical Malpractice, State of California, *Preliminary Report*, June, 1974, at 57-59.

39. H.E.W. REPORT, *supra* note 2, Appendix at 836.

40. *Id.* at 854.

41. Comment, *The Medical Malpractice Mediation Panel in the First Judicial Department of New York*, *supra* note 12, Appendix at 290; REPORT OF THE JUDICIAL CONFERENCE,

New York was particularly successful in reviewing the operation of their screening panel at every stage of its operation and is now moving toward compulsory statewide arbitration in some areas, placing the screening program on a more permanent basis and adding support and administrative staff to the program.<sup>42</sup>

The Montana Bar Association and the Montana Medical Association were innovative in establishing a voluntary screening panel in Montana. The Medical Association, however, has failed to keep track of subsequent action on claims brought before the panel. It has also failed to engage in any form of evaluation of the panel's failure to reduce the time to settlement or to reduce liability insurance rates. The Medical Association has failed to keep track of the costs involved in panel preparation, or even to compute the decision ratios with respect to claims brought before the panel.

The screening panel in Montana has reduced the hardship of finding expert medical testimony in the medical malpractice cases. It has provided an alternative forum for settlement of medical malpractice claims. But it is time to establish a complete base of information about all medical malpractice claims within Montana, whether or not the claim was filed with the screening panel.

This informational base should then be used to provide a system for malpractice claim disposition that will meet the needs of the public, the doctors, and the lawyers in administering justice. In all probability, this would involve a system of mandatory arbitration for smaller claims, a mandatory mediation or screening panel for other claims, and enhanced power in the judiciary to encourage settlement before trial.

But such a system should also incorporate an effective system of peer review to help eliminate the problem, as well as treat the symptoms, of medical malpractice. The legal profession should also encourage complete review of the professional liability insurance mechanism in Montana with the idea that whatever is learned with respect to medical malpractice insurance will all too soon become relevant to professional liability insurance for lawyers.

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STATE OF NEW YORK; vol. 13 at 13,14, vol. 16 at 218, vol. 17 at 323, vol. 18 at 323; H.E.W. REPORT, *supra* note 2, Appendix at 845 and 847.

42. Comment, *The Medical Malpractice Mediation Panel in the First Judicial Department of New York*, *supra* note 12 at 285 and 289.

## APPENDIX

The following information concerning medical malpractice liability insurance premiums was gathered from interviews with Glen R. Henckel, of Toole and Easter Insurance Company, Missoula, Montana, and Bryan Zins, Executive Director of the Montana Medical Association, Helena, Montana. It represented information on four carriers of medical malpractice liability insurance: Aetna, St. Paul, United States Fidelity and Guaranty, and Lloyds of London insurance companies.

Prior to January 1, 1975, the following classes of risk categories were used by the Insurance Services Office to establish rates:

Class 1: Physicians who do not perform or ordinarily assist in surgery;

Class 2: Physicians who perform minor surgery or ordinarily assist in surgery;

Class 3: Physicians who perform major surgery or assist in major surgery on their own patients;

Class 4: Cardiac Surgeons, Otolaryngologists—no plastic surgery, Surgeons—general, Thoracic Surgeons, Urologists, and Vascular Surgeons;

Class 5: Anesthesiologists, Neurosurgeons, Obstetricians—Gynecologists, Orthopedists, Otolaryngologists—plastic surgery, and Plastic Surgeons.

In Montana, there is a group plan written by the Aetna Insurance Company for members of the Montana Medical Association offering a one million dollar umbrella-type coverage. In the following charts, this plan will be referred to as the MMA Group Plan.

The other plans of insurance used in Montana generally offer a \$100,000/\$300,000 liability coverage. These plans take their rate figures generally from the Insurance Services Office. The rates cited are those effective on January 16, 1974, which were twenty per cent lower than the rates originally stated by the Insurance Services Office for January 1, 1974.

TABLE 1

1974 Rates (\$ per year)

Class	MMA Group Plan	Other Plans
1	538	300
2	886	515
3	1897	1137
4	2503	1515
5	3108	1894

The I.S.O. reclassified risk categories 4 and 5 into eleven categories. This reclassification took effect along with the new rate schedule on January 1, 1975.

TABLE 2

*1975 Rates* (\$ per year)

Class	MMA Group Plan	Other Plans
1	918	559
2	1598	1006
3	2865	1702
Anesthesiologists	4720	2853
Cardiac Surgeons	4720	2853
Neurosurgeons	7504	4566
Obstetricians-Gynecologists	5649	3425
Orthopedists	7504	4566
Otolaryngologists	4720	2853
Plastic Surgeons	5649	3425
General Surgeons	4720	2853
Thoracic Surgeons	7504	4566
Urologists	3792	2283
Vascular Surgeons	7504	4627

To arrive at a comparison between the 1974 and 1975 rates, the following specialties were grouped together to compare with Class 4 (1974) and the remaining individual specialties were grouped as Class 5 (1974): Anesthesiologists, Cardiac Surgeons, Obstetricians-Gynecologists, Otolaryngologists, General Surgeons, and Urologists.

On the basis of the above grouping, the following percentage increases were computed from the 1974 rates to those used in 1975:

TABLE 3

Class	MMA Group Plan	Other Plans
1	70% increase	86% increase
2	80% increase	95% increase
3	51% increase	49% increase
4 (estimated)	88% increase	88% increase
5 (estimated)	129% increase	129% increase

