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THE NEXT GENERATION OF MEDICAL MALPRACTICE DISPUTE RESOLUTION: ALTERNATIVES TO LITIGATION

Ellwood F. Oakley, III*

INTRODUCTION

In the past several years, the cost of health care malpractice insurance premiums has increased sharply.[1] While factions debate whether to attribute this increase primarily to poor performance of investments held by insurance carriers or to increased payments directly related to the cost of defending medical malpractice claims, the increases are real and widespread.[2] Certain medical specialties, including general surgery, internal medicine, and obstetrics-gynecology, have been particularly vulnerable to malpractice rate increases.[3] Like the insurance "crises" of the 1970s and 1980s, the public asks policymakers to solve the problem.[4] In 2005, federal and state legislatures are paying considerable attention to tort reform aimed at stabilizing medical malpractice insurance rates.[5] The change receiving the most attention is limitations on non-economic damages, or caps.[6] While the medical community views non-economic caps of $250,000 with relish, and the trial bar views them with anguish, no one suggests that caps alone will adequately address concerns of judicial economy and fundamental fairness.[7]

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1. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 1 (2003), *available at* http://archive.gao.gov/d31t10/145592.pdf.
2. *See id.* at 9-10.
3. *Id.*
4. *Id.*
5. *Id.* at 11; Associated Press, *Bush Pushes for Tort Reform*, *at* http://cbsnews.com/stories/2005/01/05/politics/main664838.shtml (Jan. 5, 2005).
6. U.S. GEN. ACCOUNTING OFFICE, *supra* note 1, at 12.
7. *See Bush Pushes for Tort Reform*, *supra* note 5.

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This Article concentrates on litigation alternatives in medical malpractice cases; in particular, it focuses on binding arbitration and the use of medical screening panels. As legislative bodies consider changes to the traditional tort-based approach of resolving medical malpractice claims, this Article suggests the possible increased use of alternative dispute resolution (ADR) mechanisms. Also, this Article will consider the legal environment of Georgia, with the hope that these remarks will have widespread relevance.

I. ARBITRATION

A. The Federal Arbitration Act and Preemption

The Federal Arbitration Act (FAA) illustrates Congress's policy to ensure courts uphold arbitration agreements.[8] The FAA provides that arbitration agreements in "a contract evidencing a transaction involving commerce . . . shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract."[9] The Supreme Court constrained state's limitation of arbitration agreements as follows:

> States may regulate contracts, including arbitration clauses, under general contract law principles and they may invalidate an arbitration clause "upon such grounds as exist at law or in equity for the revocation of *any* contract." What states may not do is decide that a contract is fair enough to enforce all its basic terms (price, service, credit), but not fair enough to enforce its arbitration clause. The Act makes any such state policy unlawful, for any kind of policy would place arbitration clauses on unequal "footing," directly contrary to the Act's language and Congress' intent.[10]

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8. *See* Allied-Bruce Terminix Cos. v. Dobson, 513 U.S. 265, 270 (1995) (explaining that "the basic purpose of the Federal Arbitration Act is to overcome courts' refusals to enforce agreements to arbitrate.").
9. 9 U.S.C. § 2 (2004).
10. Allied-Bruce Terminix Cos., 513 U.S. at 281 (emphasis added) (quoting 9 U.S.C. § 2).

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Georgia addresses arbitration in medical malpractice actions in two separate code provisions.[11] The Georgia Arbitration Code excludes medical malpractice predispute arbitration agreements from its coverage.[12] However, the Code allows binding arbitration where the parties enter an agreement "subsequent to the alleged malpractice and after a dispute or controversy has occurred" and where an attorney represents the plaintiff.[13] This statutory scheme results in the arbitration of few medical malpractice claims because the plaintiff elects arbitration.[14] In practice, few plaintiffs would choose a panel of experienced health care practitioners over a lay jury as the fact finder, because plaintiffs perceive they are more likely to win jury trials. However, this may be a misperception, because injured plaintiffs' chances of prevailing would likely increase via arbitration. In a recent survey of states permitting predispute arbitration, the United States General Accounting Office confirmed that "plaintiffs in medical malpractice disputes prevailed more often in arbitration than in litigation."[15] While this finding may be counterintuitive, arbitrators have more flexibility to reach an equitable balance between the parties' competing claims than do juries. The evidentiary constraints of a jury trial typically favor the medical defendant. These constraints are minimized in a typical arbitration proceeding.

The Supreme Court construes the FAA broadly, finding that it preempts any state anti-arbitration law related to matters "involving commerce," which "normally mean[s] a full exercise of Congress' constitutional power" under the Commerce Clause.[16] Consequently, if a state enacts a statute that bars arbitration agreements, the FAA will preempt the statute and uphold the arbitration agreement,

11. O.C.G.A. §§ 9-9-2, -62 (2004).

12. O.C.G.A. § 9-9-2(c)(1) (2004).

13. O.C.G.A. § 9-9-62 (2004).

14. One finds evidence of the lack of support for postdispute arbitration agreements by the fact that "only 4.2% of litigators always recommend post-dispute arbitration to their clients." Keith Maurer, *Designing and Implementing a Successful Healthcare Consumer ADR Program*, HEALTH LAWYERS NEWS, January 2005, at 32 (citing a 2003 study by the ABA Section of Litigation Task Force of ADR Effectiveness). In the 16 years since the enactment of O.C.G.A. § 9-9-62, the author is unaware of any cases in which the plaintiff elected arbitration.

15. Maurer, *supra* note 14, at 31 (citing U.S. GEN. ACCOUNTING OFFICE, *supra* note 1).

16. Allied-Bruce Terminix Cos. v. Dobson, 513 U.S. 265, 273 (1995).

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provided the court finds the "transaction" in fact "involve[s]" interstate commerce.[17]

In *Doctor's Associates v. Casarotto*, the Supreme Court clarified the purpose and preemptive reach of the FAA:

> State law, whether of legislative or judicial origin, is applicable *if* that law arose to govern issues concerning the validity, revocability, and enforceability of contracts generally. A state-law principle that takes its meaning precisely from the fact that a contract to arbitrate is at issue does not comport with [the text of § 2].[18]

The Court's interpretation of the FAA makes it difficult for states to enact statutes that limit the enforceability of both pre- and post-dispute arbitration provisions.[19]

Courts have held that state laws affecting arbitration agreements within the health care industry are subject to federal preemption because health care affects interstate commerce.[20] Therefore, the FAA applies to bar state statutes that "place arbitration clauses in medical services agreements in a class apart not only from 'any contract' but also from all other arbitration agreements."[21] Presumably, the FAA would preempt the Georgia Arbitration Code because section 9-9-2(a)(1) of the Georgia Code specifically excludes medical malpractice predispute arbitration agreements from its coverage.[22]

In *McGuffey Health & Rehabilitation Center v. Gibson*, the Alabama Supreme Court faced the issue of whether a clause in a nursing home admission agreement requiring medical malpractice claim arbitration "evidenced a transaction that substantially affect[ed] interstate commerce" such that the FAA preempted an Alabama

17. *Id.* at 281.

18. Doctor's Assocs., Inc. v. Casarotto, 517 U.S. 681 (1996) (citing Perry v. Thomas, 482 U.S. 483, 493 n.9 (1987)).

19. Maurer, *supra* note 14, at 30.

20. *Id.* (citing Toledo v. Kaiser Permanente Med. Group, 987 F. Supp. 1174, 1180 (N.D. Cal. 1997)).

21. Morrison v. Colo. Permanente Med. Group, 983 F. Supp. 937, 943 (1997).

22. O.C.G.A. § 9-9-2(a)(1) (2004).

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statute that prohibited arbitration.[23] The Alabama court stated that the party seeking to compel arbitration has the burden to show that an arbitration agreement existed and that it substantially affected interstate commerce.[24] The court concluded that the FAA preempted the Alabama statute based on the nursing home's receipt of Medicare funds and certain materials which came from out-of-state sources.[25] The Alabama Supreme Court reached the same conclusion in the 2004 case of *Briarcliff Nursing Home, Inc. v. Turcotte*.[26] The court found the FAA preempted the state statute due to interstate commerce.[27] The court examined the following factors: the nursing home had offices outside of the state, had several out-of-state patients, and received regular supply shipments from sources outside of the state.[28]

Consequently, it is hard to imagine a medical malpractice case that does not involve interstate commerce and would not lead to FAA preemption of the Georgia Arbitration Code.[29] Modifying section 9-9-62 of the Georgia Code to allow for predispute arbitration contracts and repealing section 9-9-2(c)(1) of the Georgia Code would place arbitration contracts in medical malpractice claims on "equal footing" and would permit, but not require, patients and medical personnel to enter into predispute arbitration agreements. Section 9-9-2 of the Georgia Code presently allows for this change without materially altering the statute's basic framework. The advantage of changing the statute through legislation, rather than through the courts and preemption, is that it allows legislators to decide exactly what type of arbitration model is best for Georgia.

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23. McGuffey Health & Rehab. Ctr. v. Gibson, 864 So.2d 1061, 1062 (2003).

24. *Id.*

25. *Id.* at 1063.

26. Briarcliff Nursing Home, Inc. v. Turcotte, No. 1012193 & 101295, 2004 WL 1418698, at *5 (Ala. June 25, 2004).

27. *Id.*

28. *Id. But see* Columbus Anesthesia Group, P.C. v. Kutzner, 459 S.E.2d 422 (1995) (holding that the FAA did not preempt the state arbitration code because an employment contract between a doctor and his employer only dealt with the doctor's membership in a Georgia professional corporation providing services in Georgia and therefore did not involve interstate commerce).

29. This does not limit state courts in applying general contract law to invalidate an arbitration agreement based on a contract's validity, revocability, or enforceability. Doctor's Assoc., Inc. v. Casarotto 517 U.S. 681, 686-87 (1996).

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B. Binding Arbitration

Presently, arbitration of medical malpractice claims is an option in 13 states, and 12 states mandate arbitration in some cases.[30] Only a few states of those that allow arbitration expressly permit the practice of contracting to binding arbitration before injury occurs.[31] Encouraging predispute agreements to arbitrate medical malpractice claims may be appealing for a variety of reasons.[32] Advocates of arbitration often tout the primary benefits to be the system's speed, convenience, and cost-effectiveness.[33] California, Tennessee, and Louisiana have adopted legislation expressly approving predispute contract provisions for binding arbitration.[34]

Compared to other alternatives to litigation, binding arbitration tends to be controversial.[35] When faced with litigation over the legality of mandatory arbitration, California courts have consistently upheld their system's validity and constitutionality.[36] Other state courts have generally upheld the validity of binding arbitration in medical malpractice cases, if parties make the agreements procedurally fair.[37]

The Tennessee Code declares contracts to enter into arbitration agreements prior to an injury "valid, enforceable and irrevocable."[38] In *Buraczynski v. Eyring*, the Tennessee Supreme Court considered a

30. WYOMING HEALTHCARE COMM'N, ALTERNATIVE DISPUTE RESOLUTION: MEDIATION AND ARBITRATION (2004) (on file with the Georgia State University Law Review) [hereinafter WYOMING HEALTHCARE COMM'N: ADR Report]. Alabama, California, Florida, Georgia, District of Colombia, Illinois, Minnesota, New York, Tennessee, Texas, Washington, Wisconsin, and Wyoming allow arbitration. *Id.* Alaska, Delaware, Hawaii, Indiana, Louisiana, Maryland, Michigan, Montana, New Jersey, North Carolina, Utah, and West Virginia require arbitration. *Id.*

31. *See id.* at 7-15.

32. *Id.* at 2.

33. *Id.*

34. CAL. CIV. PROC. CODE § 1295 (2004); LA. REV. STAT. ANN. § 9: 4231 (2004); TENN. CODE ANN. § 29-5-302 (2004).

35. *See Maurer*, *supra* note 14, at 30-32.

36. The California Code allows for rescission within 30 days of signing a contract containing an arbitration clause, and where a contract is drafted in accordance with the statute, it is not unconscionable or a contract of adhesion. CAL. CIV. PROC. CODE § 1295(c) (2004).

37. Mac Gibson & Josh Belinfante, *The Need for Mandatory Medical Review Panels: The Medical Malpractice Crisis in Georgia*, Georgia Public Policy Foundation, *at* http://www.gppf.org/article.asp?RT=11&p=pub/LegalReform/MedicalMalpractice/malpractice_ffull_study.htm (last visited Apr. 9, 2005).

38. TENN. CODE. ANN. § 29-5-302 (2004).

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case involving the enforceability of a binding arbitration agreement in a contract between a physician and a patient.[39] In the case, the court found the contract to be one of adhesion, but upheld the validity of the arbitration clause.[40] The court held that the arbitration agreements at issue "contain[ed] no unconscionable or oppressive terms" rendering them unenforceable.[41]

Louisiana also allows predispute, binding agreements to require arbitration of medical malpractice claims.[42] The Louisiana statute provides a sample medical arbitration agreement that states, "provisions of such contract shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract" when a patient and medical practitioner enter into an arbitration agreement.[43] In the absence of an agreement to submit to binding arbitration, parties to medical malpractice claims submit them to a medical review panel, as discussed below.[44]

As previously mentioned, the Georgia Arbitration Code specifically excludes medical malpractice cases from its coverage.[45] The Code does provide a system of arbitrator appointment that is appealing in the medical malpractice context.[46] If an arbitration agreement contains no specified method of appointing arbitrators, or if the agreed upon method fails, then the court may appoint an arbitrator or arbitrators to handle the case.[47] This latitude allows the trial court to appoint an expert, which may include an expert in the field of the defendant's practice, an experienced trial lawyer, or a revered arbitrator.

39. Buraczynski v. Eyring, 919 S.W.2d 314, 316 (Tenn. 1996).
40. *Id.*
41. *Id.*
42. LA. REV. STAT. ANN. §§ 9:4201, :4231 (2004).
43. LA. REV. STAT. ANN. § 9: 4231 (2004).
44. LA. REV. STAT. ANN. § 1299.47(A)(1)(a) (2004).
45. O.C.G.A. § 9-9-2 (2004).
46. O.C.G.A. § 9-9-7 (2004).
47. *Id.*

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II. MEDICAL MALPRACTICE SCREENING PANELS

Medical malpractice screening panels "review malpractice claims before trial, and they make non-binding recommendations to parties in an effort to induce settlements."[48] These panels have several purposes: "to identify potentially weak claims early in the litigation; to encourage settlement of valid claims; and also, in cases that do not settle and proceed to trial, to provide a neutral source of expertise that can help to inform the jury's view of the case at trial."[49] Proponents of medical screening panels believe it is difficult for lay persons to determine the existence of medical error without the intervention of medical experts. Most judges and jurors do not have either the scientific training or the experience in the health care field to give them sufficient background to judge medical testimony. As a result, courts require medical experts to help the fact finder evaluate a claim of medical error at trial. Medical screening panels serve a similar function prior to trial. If established with proper safeguards, medical screening panels may provide a viable litigation alternative in medical malpractice claims. In some cases screening panels serve to help reduce the cost and time of litigation, discourage frivolous claims, and where a claim eventually ends up in court, may provide an unbiased source of expert information for the jury.[50] Screening panels also allow medical professionals to be monitored by members of their own profession who have more expertise in the particular field than the average juror.[51] In 2003, the American Medical Association compiled a list of states it considered to be experiencing a medical malpractice crisis.[52] Of the 19 crisis states, only 3 were

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48. Gibson & Belinfante, *supra* note 37.

49. WYOMING HEALTHCARE COMM'N, MEDICAL REVIEW PANEL REPORT (2004) (on file with the Georgia State University Law Review) [hereinafter WYOMING HEALTHCARE COMM'N: MRP Report].

50. CATHERINE T. STRUVE, THE PEW CHARITABLE TRUSTS, EXPERTISE IN MEDICAL MALPRACTICE LITIGATION: SPECIAL COURTS, SCREENING PANELS, AND OTHER OPTIONS 55-56 (2003), *available at* http://www.pewtrusts.com/ideas/ideas_item.cfm? (noting that some of the goals of medical screening panels may be accomplished, but that "neither theory nor practice strongly supports proponents optimistic view of screening panels" and concluding that "panels are not an optimal way to provide expertise to the jury").

51. *See id.* at 55.

52. Gibson & Belinfante, *supra* note 37.

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among the 21 states using mandatory medical screening panels.[53]

With screening panels, the devil is truly in the details. Unless implemented with substantive clout, screening panels can create another level of judicial inefficiency.[54] Medical screening panels may actually increase the time and cost of litigation of a subsequent trial.[55] In addition, some studies have shown that the existence of a screening panel may actually increase the number of claims filed.[56] Although 31 states have implemented some form of screening panel, presently only 19 states continue to permit the use of screening panels in medical malpractice cases.[57] In states that have discontinued the practice, either the courts found the process to be unconstitutional or the state legislature found the process cumbersome and ineffective.[58] Few states that permit medical screening panels make significant use of them today, but it is instructive to review several states' experiences with the implementation of screening panels.[59]

A. *Differing Approaches to the Use of Medical Review Panels*

1. *Florida*

In Florida, one party to a medical malpractice claim may make a request for voluntary binding arbitration utilizing a review panel, which the opposing party may accept or reject.[60] The review panel determines liability as well as damages, which are subject to statutory limits.[61] Three members comprise the review panel—one selected by the claimant, one selected by the defendant, and one administrative

53. *Id.*

54. STRUVE, *supra* note 50, at 56 (explaining that some states have ceased using medical screening panels because they "caused undue delay").

55. *Id.* at 62. Where the findings are admissible, "parties will feel the need to engage in exhaustive discovery and a plenary presentation." *Id.* Where not admissible, parties will have to present their case twice. *Id.*; WYOMING HEALTHCARE COMM'N: MRP Report, *supra* note 49, at 2.

56. STRUVE, *supra* note 50, at 60. Other studies have indicated that medical screening panels have no effect on the number of claims. *Id.*

57. *Id.* at 57. For a discussion of legal challenges to medical screening panels, see WYOMING HEALTHCARE COMM'N: MRP Report, *supra* note 49, at 3.

58. *See* STRUVE, *supra* note 50, at 56.

59. WYOMING HEALTHCARE COMM'N: MRP Report, *supra* note 49, at 1.

60. FLA. STAT. ANN. § 766.207 (2004).

61. FLA. STAT. ANN. § 766.207(7) (2004).

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law judge who serves as the chief arbitrator.[62] An interesting aspect of Florida's system is that it provides both parties with incentives to enter into voluntary arbitration.[63] If the defendant rejects the claimant's request for arbitration, and the claimant subsequently successfully proves medical malpractice at trial, the claimant may receive attorney's fees up to 25% of the award.[64] Alternatively, if the claimant rejects the defendant's request for arbitration, then "the damages awardable at trial shall be limited to net economic damages, plus non-economic damages not to exceed $350,000 per incident."[65]

2. Michigan

Michigan has established mediation panels to hear all medical malpractice cases prior to trial.[66] The mediation panel consists of five voting members—three licensed attorneys and two licensed and registered health care professionals.[67] Under the Michigan system, parties cannot testify, but attorneys may submit briefs and conduct oral argument before the panel.[68] The panel renders an evaluation which includes an assessment of damages.[69] If either party disagrees with the panel's evaluation, then the case goes to trial.[70] Otherwise, the court enters judgment for the amount of damages.[71] Unlike some states that permit the introduction of the review panel's decision at the subsequent trial, Michigan has a somewhat different approach to encourage acceptance of the review panel's decision: "If a party has rejected an evaluation and the action proceeds to trial, that party shall

62. FLA. STAT. ANN. § 766.207(4) (2004).

63. WYOMING HEALTHCARE COMM'N: MRP Report, *supra* note 49, at 6.

64. FLA. STAT. ANN. § 766.209(3)(a) (2004).

65. FLA. STAT. ANN. § 766.209(4)(a) (2004). Florida caps non-economic damages in arbitration at $250,000 per incident, "calculated on a percentage basis with respect to capacity to enjoy life." FLA. STAT. ANN. § 766.207. Arguably, this would diminish the claimant's incentive to submit to binding arbitration. *Id.*

66. MICH. COMP. LAWS ANN. §§ 600.4903, .4919 (2004). In addition, Michigan law allows for binding arbitration in medical malpractice claims as long as "the total amount of damages claimed is $75,000 or less, including interests and costs." MICH. COMP. LAWS ANN. § 600.2912g(1) (2004).

67. MICH. COMP. LAWS ANN. § 600.4905 (2004).

68. MICH. COMP. LAWS ANN. § 600.4913 (2004).

69. MICH. COMP. LAWS ANN. § 600.4919 (2004).

70. *Id.*

71. *Id.*

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pay the opposing party's actual costs unless the verdict is more favorable to the rejecting party than the mediation evaluation."[72] A study of this system found that, on average, the arbitration panel offered higher awards than those received through trial or settlement proceedings.[73] It also found that the panel decisions are less "erratic" than the range of awards produced at trial and "actual negligence had an impact on accepting mediation awards."[74]

3. *Virginia*

Virginia also provides a medical malpractice review panel on request of either party.[75] The Supreme Court of Virginia selects the panel and the panel includes "(i) two impartial attorneys and two impartial health care providers, licensed and actively practicing their professions in the Commonwealth and (ii) the judge of a circuit court in which the action was filed, who shall preside over the panel."[76] The Board of Medicine submits a list from which to select the health care providers, and the Virginia Bar provides the list from which to select the attorneys.[77] The parties submit their evidence to the panel in written form and may request a hearing before the panel.[78] In contrast to Florida proceedings, the opinion of the review panel is admissible as evidence in a subsequent court proceeding, but the opinion is not conclusive.[79] Both parties may call panel members to testify in court, excluding the judge.[80] The panelists receive absolute immunity, protecting them from civil liability.[81]

72. MICH. COMP. LAWS ANN. § 600.4921(1) (2004). "However, if the opposing party has also rejected the evaluation, that party is entitled to costs only if the verdict is more favorable to that party than the mediation evaluation." *Id.*

73. Ann. H. Nevers, *Medical Malpractice Arbitration in the New Millennium: Much Ado About Nothing*, 1 PEPP. DISP. RESOL. L.J. 45, 68 (2000).

74. *Id.*

75. VA. CODE ANN. § 8.01-581.2(A) (2004).

76. *Id.*; VA. CODE ANN. § 8.01-581.3 (2004).

77. VA. CODE ANN. § 8.01-581.3 (2004).

78. VA. CODE ANN. § 8.01-581.4 (2004).

79. VA. CODE ANN. § 8.01-581.8 (2004).

80. *Id.*

81. *Id.*

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4. *Louisiana*

In Louisiana, absent an agreement by both parties to submit to binding arbitration, all medical malpractice claims must go before a medical review panel.[82] The panel consists of three health care providers licensed in Louisiana, one chosen by each side and the third agreed upon by both parties, and one attorney, selected by agreement of both parties, who acts in a chairman capacity and has no vote.[83] The panel's sole function is to determine "whether or not the evidence supports the conclusion that the defendant or defendants failed to act within the appropriate standards of care."[84] If a court proceeding ensues subsequent to an opinion rendered by the medical review panel, the review panel's report is admissible as evidence but is not conclusive, and the parties may call the panel members to give expert testimony.[85]

B. *Considerations for Implementing Medical Screening Panels in Georgia*

As currently structured, some states allow the screening panel's findings to be admissible at a subsequent trial while others do not.[86] This draws criticism from both opponents and proponents of medical screening panels. They argue that if the panel's decision is inadmissible in a subsequent trial, then there is little reduction in the incentive for the losing party to accept the panel's decision. If efficiency is a high priority in utilizing medical screening panels, it follows that the findings should be admissible, thereby increasing the incentive to accept the panel's findings. Some proponents of medical screening panels also argue that fairness dictates the admissibility of the panel's decision at trial, including any concurring and dissenting

82. LA. REV. STAT. ANN. § 1299.47(A)(1)(a) (2004). The parties may agree to waive the review panel. LA. REV. STAT. ANN. § 1299.47(B)(1)(a)(ii)(c) (2004).

83. LA. REV. STAT. ANN. §§ 1299.47(C), (C)(2) (2004).

84. LA. REV. STAT. ANN. § 1299.47(G) (2004).

85. LA. REV. STAT. ANN. § 1299.47(H) (2004).

86. *See* Gibson & Belinfante, *supra* note 37, at n.76 for a listing of states in which panel reports are admissible evidence.

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opinions.[87] As a policy matter, it seems unwise to establish a framework for screening panels in Georgia without giving the results a presumption of validity in a subsequent trial. Likewise, it makes sense to establish a monetary incentive to accept the panel's findings as Florida currently provides.

Another question arising in deciding how to implement a medical screening panel is deciding on the number of screening panel members and who those members should be. In most states the panel consists of three to five members who are either exclusively medical professionals or are a combination of medical professionals, lawyers, and judges. As mentioned above, in Louisiana, the medical screening panel consists of one attorney and three physicians; and in Virginia, the medical screening panel consists of one judge, two attorneys, and two health care providers.[88] In contrast, in Connecticut, the panel consists of two doctors, one of whom shares the defendant's specialty, and one personal injury attorney.[89] Finally, in Alaska the medical screening panel consists of three experts, and a judge orders their area of expertise, giving "the parties the opportunity to object or make suggestions" as to the selection.[90] States that experience success with panels have two features in common: all or most of the voting members of the panel are medical experts, and the recommendation of the panels is admissible in subsequent legal proceedings.[91]

C. The Role of Medical Experts in Medical Malpractice Cases

States have mixed experiences using medical screening panels.[92] Nevertheless, medical malpractice cases will inevitably require

87. Gibson & Belinfante, *supra* note 37.

88. *See* discussion *supra* Parts II.A.3, II.A.4.

89. WYOMING HEALTHCARE COMM'N: MRP Report, *supra* note 49, at 5.

90. ALASKA STAT. § 09.55.536 (2004).

91. *See* WYOMING HEALTHCARE COMM'N: MRP Report, *supra* note 49, at 4. The report recommends that medical review panels include medical experts, partly to reinforce physician confidence in the system, and that the panel's findings be admissible at trial, to ensure that the panel is not viewed as a "mere pretrial formality" by the parties. *Id.* It noted that panels may not provide "neutral information that the jury could use," which would cut against the admissibility of the review panel reports as evidence. *Id.*

92. *See* WYOMING HEALTHCARE COMM'N: MRP Report, *supra* note 49.

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medical experts to render technical assistance to the finders of fact. Creative legislation could make efficient use of the expert short of trial.

Several states, including Georgia, require an expert medical affidavit expressing an opinion of medical negligence as a prerequisite to initiating litigation.[93] People should commend this requirement because it tends to eliminate the truly weak claims. However, medical experts engaged by either side have less credibility than a court-sanctioned independent expert. For states without the prelitigation affidavit requirement, use of a court-appointed medical expert to review the claim at the litigation's outset (or even before) would serve a similar purpose.

Court systems with early neutral evaluation programs would seem to be a natural fit for medical panels. A "panel" of one is more efficient, particularly if the evaluation consisted primarily of a medical chart review and examination of party affidavits. The same medical expert provides great assistance in mediation (whether court ordered or voluntary), and in arbitration for panels without medical expert members. Georgia's medical malpractice arbitration statute currently provides for the selection of expert(s) to assist the arbitrator.[94] An independent medical expert could also assist the trial judge in determining scientific validity of testimony during *Daubert* motions before trial. It is unrealistic to expect most judges to have the background and training to evaluate claims involving statistical nuance and the scientific methods. Why not rely upon trained members of the medical community who have no stake in the outcome of the litigation? The independent medical expert would provide welcome support to the fact finder, whether an arbitration panel, judge, or jury. The independent expert consultant concept is flexible enough to accommodate virtually any ADR procedure in use by the local court system.

93. O.C.G.A. § 9-11-9.1 (requiring said affidavit to be included in the complaint).
94. O.C.G.A. § 9-9-7 (2004).

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III. MEDIATION

Courts favor non-binding mediation, and it is gaining favor with health care officials across the country.[95] In the context of pending litigation, mediation may either be mandatory by the courts or left to the parties' discretion.[96] Georgia currently permits voluntary mediation, and insurers are encouraging health care professionals to try to resolve claims via mediation. Some counties in Georgia have experimented with court ordered mediation as an adjunct to litigation. For example, Cobb County has an alternative dispute resolution system in which the judge may order mediation of "any contested civil or domestic matter."[97] The parties involved then must agree upon a mediator from a list of certified mediators in the mediation department.[98] The Uniform Rule that provides for complete confidentiality governs the confidentiality of the mediation process.[99] All that the mediation process requires is the appearance of the parties.[100] The purpose of the process is simply to "open the lines of communication and to explore all possibilities of settlement."[101]

In 1998, the Superior Court of Cobb County expanded the mediation process to include the option of selecting Case Evaluation. Case Evaluation is a system that allows the parties to agree to submit their case in front of a lawyer with expertise in the subject matter of the litigation. The lawyer acts as a neutral evaluator of the case. The neutral evaluator reviews the facts and gives his opinion as to the case's likely outcome. The process is nonbinding, but serves as a gauge for the parties in order to bring both sides closer to a pretrial resolution.

The effectiveness of this process is hard to judge. Some estimates put the settlement rate in these counties around 80%. Given the high

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95. *See* WYOMING HEALTHCARE COMM'N: MRP Report, *supra* note 49, at 1 (explaining that states are "leaning toward mandatory arbitration or mediation systems operated by the courts").

96. *See id.* at 2.

97. Cobb Co. Superior Court Mediation Rules § 1(a) [hereinafter CCSCMR].

98. CCSMR § 4(a).

99. CCSMR § 7.

100. CCSMR §§ 9, 10.

101. CCSMR Definition.

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rate of pretrial settlement in the ordinary course of litigation, it is hard to measure the usefulness of the process. If there is no real gain in judicial efficiency attributable to mediation of medical malpractice claims, then mandatory mediation becomes another cost in the already expensive litigation process. Another problem that has arisen with requiring mediation is that it is difficult to enforce "good faith" requirement for the parties to have to follow. The mediation process is confidential. Therefore, there is no way of effectively reporting "good faith" violations.

CONCLUSION

The current wave of tort reform measures the federal government and states are considering focuses primarily on placing caps on non-economic damages. While that approach may have merit in stabilizing medical malpractice insurance premiums, it ignores claims of the trial bar and patient advocates that legitimate claims will be more difficult to pursue. At the same time policy makers address the health care economic crisis of the moment, this Article urges them to also take a fresh look at providing a fair and efficient process for eliminating non-meritorious claims. Professionals have enough experience with ADR tools of mediation, arbitration, and screening panels to shape the next generation of medical malpractice dispute resolution. Litigants should welcome a process that utilizes rational fact-finding to supplement the emotional cauldron of a jury trial, especially if it makes the claiming process quicker, cheaper, and more predictable. Safeguards should be put in place so as not to increase the financial burden on claimants. If carefully structured, all parties can come away from the next generation of medical malpractice dispute resolution feeling that it was fundamentally fair.

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