Correspondence

Malpractice Arbitration: A Response

Dear Editors:

In his article, *Legislative Efforts to Reform Medical Malpractice: Unconstitutional in Practice?*, MEDICOLEGAL NEWS 8(4): 8 (September 1980), Lee J. Dunn discusses appellate court decisions that have reviewed programs in three states, including the Pennsylvania system. In *Edelson v. Soricelli*, 610 F.2d 131 (3d Cir. 1979), the conclusions of Judges Aldisert and Rosenn, that the system is a dismal failure, could have resulted only from incomplete statistics presented to the Court of Appeals. We can understand why counsel avoided presenting the accomplishments of the arbitration system in Pennsylvania. The true story would outrage their clients, both plaintiffs and defendants, and would show that the delay in holding hearings is caused by lawyers running cases at their own pace.

The Pennsylvania system provides plaintiffs with a full hearing before an arbitration panel that is empowered to render a decision and award damages. Absent a request for a trial de novo in the courts, a panel's decision is final and fully enforceable. A panel's findings of fact and its decision on liability are admissible as evidence at the trial de novo; the amount of damages awarded is not.

Since medical malpractice cases are usually complex, requiring extensive preparation on both sides, an immediate hearing is impossible. However, we find that trial attorneys often consume several years in pre-trial motions and preparation. Under our system, counsel for plaintiff or defendant may file a Certificate of Readiness to proceed to an arbitration hearing. In the 3,717 claims filed with the Arbitration Panels for Health Care between April of 1976 and July of 1980, requests for arbitration hearings were filed in only 249 cases. Since we can provide arbitration panels for all claims ready, we are concerned about counsels' delays in requesting hearings.

The Pennsylvania Supreme Court has recognized the delay in civil litigation and has attempted to prod trial counsel to action by adopting rules providing for special damages for delay against the defendants[1] and an eight month limit for preparing cases before the courts.[2] Damages for delay may also be awarded in claims before the arbitration panel. However, at the suggestion of the Supreme Court's administrative office, we have adopted a twelve month limit,[3] recognizing that medical malpractice claims are complex and require more time to prepare. Failure to prepare a claim for arbitration within twelve months may result in its dismissal. We hope these innovations will promote prompter action by counsel.

In December of 1979, our state legislature unanimously passed and Governor Thornburgh signed amendments to the Health Care Services Malpractice Act which streamlined arbitration panel selection and reduced the number of arbitrators from seven to three.[4] The medical malpractice panels are now the same size as arbitration panels in the local courts which hear other claims.

As of July 31, 1980, 89 percent of the claims filed in 1976 and 68 percent of the claims filed in 1977 have been ended; this decreases to 39 percent of claims filed in 1978, 18 percent of the claims filed in 1979, and 5 percent of claims filed in 1980. While a few diligent counsel complete discovery and request arbitration panels within a few months after commencing the action, these counsel are clearly the exception. Most attorneys seem to follow the practice described to us by a prominent Pennsylvania plaintiffs' attorney: "I needn't tell you that too many of us in trial practice are specialists in delay and procrastination — and more delay, and then some more delay."

The changes described above are beginning to take effect and we anticipate a marked increase in the number of requests for arbitration hearings for claims commenced on or before February 12, 1980.

We must also emphasize that the number of arbitration hearings is not, alone, an accurate measure of the operation of this office. In addition to providing arbitration hearings, we handle all preliminary motions. Our program also requires at least one conciliation conference in every claim. Over one thousand such conferences have been held, resulting in hundreds of offers of settlement by defendants or discontinuances by plaintiffs. Through July 31, 1980, 1,025 claims have been closed by agreement of the parties or on procedural grounds before an arbitration hearing was even held. This leaves 2,501 claims where counsel have not yet finished preparing their cases.

In the short time that we have been in existence, we have assembled a staff with expertise in motion work, in conciliation conferences, and in arranging arbitration hearings. We have a system ready and able to provide prompt and efficient hearings for all medical malpractice claims. It is now the responsibility of counsel to complete their preparation and to request a hearing. It is the responsibility of the clients, both plaintiffs and defendants, to utilize counsel who will diligently and promptly prepare their cases for arbitration.

Arthur S. Frankston, Esq.
Administrator
Arbitration Panels for Health Care
Commonwealth of Pennsylvania
Harrisburg, Pennsylvania

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1. PA. R. CIV. PROC 238.
2. An order of the Pennsylvania Supreme Court entitled, *Prompt Certification for Trial of Civil Cases*, PENNSYLVANIA BULLETIN Vol. 9, p. 3936 (December 1, 1979).
3. 37 Pa. Code §171.123.
4. Health Care Services Malpractice Act of October 15, 1975, P.L. 390, *as amended*, 40. PA. STAT. ANN. §1301.101, *et seq.*, *as amended* P.L. 562, No. 128, December 14, 1979.

Editor's Note: *On June 24, 1980, the Pennsylvania Supreme Court heard oral argument in* Mattos v. Thompson, *a case that challenges the constitutionality of the arbitration provisions of the Health Care Services Malpractice Act. According to the* PENNSYLVANIA LAW JOURNAL[1], *the questions asked by the justices were "tinged with skepticism." One justice is quoted as asking the state's attorney, "Are you arguing that we should preserve a system with the poorest record in the Commonwealth?" As* MEDICOLEGAL NEWS *went to press, the court had not released its opinion.*

References

1. PA. LAW J. (Monday, June 30, 1980).

Rattigan Contest Winner

Dear Mr. Doudera:

I wish to thank you and all the members of the American Society of Law and Medicine for selecting my manuscript, entitled *Transfer Trauma:*

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Tort Liability of Nursing Homes for Involuntary Transfer of Patients, for First Prize in the 1980 John P. Rattigan Memorial Essay Competition. The $300 is greatly appreciated and, as I am sure you know, will be helpful in meeting my educational expenses. I enjoyed researching and writing the paper and being awarded First Prize was truly "icing on the cake."

Again, my sincerest thanks.

Mark D. Owen
Washington University
School of Law
St. Louis, Missouri

Allocating Responsibility by Contract

Dear Editors:

Society is currently experiencing a historic transition in the way it addresses questions of responsibility for health. Constitutional rights and doctrines of informed consent offer the basis for change, but individuals, "physicians" and their advisors must take the initiative to clarify the confusion which accompanies any change. Six years ago, my studies of malpractice cases revealed recurrent misunderstandings about the role of "physicians" and I wondered if the medical role could not be clarified by encouraging the definition of individual and professional responsibility by express agreement.

Although the doctor-patient relationship is fundamentally contractual in nature, questions of professional responsibility have always been litigated as torts. Courts have "implied" a contract when questions of fees arise, and we are now grappling with "informed consent," a contract principle which has evolved as a tort defense. I suggest that our difficulties with this doctrine and many other issues may be relieved by addressing the contractual nature of the relationship *expressly*.

The recent ASLM conference in Los Angeles on the *Legal and Ethical Aspects of Treatment for Critically and Terminally Ill Patients* raised fundamental questions about quality of life *choices*, that, I submit, need not be decided according to criminal law principles embodied in murder statutes. If *choice* is the real issue, then *contract* is the appropriate context for our thinking. The conference also demonstrated the frustration experienced by health professionals in seeking "informed consent" without any way of knowing what the patient actually understands. If this doctrine represents a judicial stepping stone from tort to contract, we have in the latter the opportunity to examine the patient's goals and expectations in the relationship. Courts will modify the doctrine to suit the needs that are discovered in the process.

University of Chicago Professor Richard Epstein has laid the foundation for judicial recognition of contracts in two scholarly articles which recall our natural evolution in other fields from tort to contract as we learn how to allocate risks previously litigated according to principles of common law negligence.[1] Epstein suggests that contract thinking is not only a good idea now, but that it is historically inevitable.

Another confirmation of the contractual nature of health care relationships is the arbitration agreement, which merely shifts the forum for resolving disputes. It does little to shed light on the kind of agreements that are necessary to make the doctor-patient relationship work, and may promote controversy by focusing initial attention on the anticipation of failure. If arbitration agreements make any sense at all, they suggest to me that even greater productivity might come from exploring the functional responsibilities of doctor and patient.

Rogers v. Okin,[2] discussed in the April 1980 issue of MEDICOLEGAL NEWS in an article by Dr. Daryl Matthews, may represent the latest step in judicial concern for freedom of choice in medical care. It suggests that the First Amendment, in addition to the right of privacy, may apply to one's choice of medical treatment. If our job is to evaluate the allocation of choices, contract is a more appropriate context than tort or criminal law.

My experience conducting seminars for health professionals suggests that the main problem is clarifying the relationship between patient responsibility and medical responsibility. The popular banner of individual responsibility has not begun to be defined. Doctors can limit professional liability by discussing their roles in terms of diagnosing and treating pathology and defining patient responsibility in terms of the dynamics of health that are within individual control. We need not view this as a contract that needs to be written by lawyers. Physicians and patients should be encouraged to make a plan, which identifies a purpose, complementary responsibilities, and a term. A verbal agreement is the result of a process of contracting, and may be evidenced by the conduct of the parties, notes, memoranda, or letters.

Furthermore, Epstein suggests that once we make this shift in context, we can explore contractual limitations of damages, and even consider limiting liability to gross negligence, which I believe might be defined with greater precision by a progressive medical profession.

As an Advisor to the San Francisco Consortium Collaborative Health Program, a federally funded study of the allocation of responsibility between doctors, nurses, and consumers, I have observed the evolution of a model for contracting. The study examines the behaviors and attitudes which are conducive to collaboration and those which are barriers to making meaningful agreements, which is the object of collaboration. This pioneering work offers physicians the opportunity to develop a plan for implementing a definition of their roles and responsibilities in accord with that which their science prepares them to assume.

The precedence which our legal system gives to private agreements over common law principles gives doctors an alternative to judicially defined standards of practice. Physicians should establish seminars for structuring relationships by contract, develop a plan for clarifying the nature of their own professional responsibilities, and encourage public education about the dynamics of health that are within individual control.

Jerry A. Green, J.D.
Mill Valley, California

References

1. *Contracting Out of the Medical Malpractice Crisis*, PERSPECTIVES IN BIOLOGY AND MEDICINE, Winter 1977 at p. 228; *Medical Malpractice: The Case for Contract*, AMERICAN BAR FOUNDATION RESEARCH JOURNAL 1976(1): 87-149.
2. *Rogers v. Okin*, 478 F. Supp. 1342 (D.Ma. 1979).

Letters Invited

The Editors of MEDICOLEGAL NEWS welcome letters from readers concerned with published articles and with related issues. Double spaced letters should be sent to Managing Editor, MEDICOLEGAL NEWS, 520 Commonwealth Ave., Boston, MA 02215.

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