DARK VICTORY: THE DOOM OF MEDICAL MALPRACTICE PANELS

*by Marina Corodemus**
*and Helen Ver Strate***

Introduction

A crisis in medical malpractice has developed over the past twenty years throughout the United States. The "crisis,"[1] as it has been characterized by many professionals, has resulted from escalating insurance premiums on medical malpractice policies[2] due to the increasing number of malpractice claims and the settlement of those claims.[3] The Department of Health, Education and Welfare (HEW)[4] suggested that this crisis is the result of a "complex of problems involving interacting medical, legal, sociological, psychological and economic factors."[5]

These problems have found their way into the courtroom in the form of expensive, complicated, and lengthy litigation paid for by insurance carriers.[6] A few large insurance companies holding the majority of medical malpractice policies have passed these expenses along to policyholders at a much higher rate than has been levied on any other professional

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* B.A., Boston University; J.D., Seton Hall University School of Law, 1980. Associated with Corodemus and Corodemus, Perth Amboy, New Jersey.

** B.A., Douglass College; J.D., Seton Hall University School of Law, 1980. Associated with Abramoff, Apy, Fox & Zaro, Red Bank, New Jersey.

[1] Curran, *The Malpractice Insurance Crisis: Short-Term and Long-Term Solutions*, 293 NEW ENG. J. OF MED. 24 (1975). *See also* Blaut, *The Medical Malpractice Crisis—Its Cause and Future*, 44 INS. COUNSEL J. 114 (1977).

[2] *Malpractice Insurance Crisis, supra* note 1, at 24.

[3] U.S. DEP'T. OF HEALTH, EDUCATION & WELFARE, Pub. No. (OS) 73-88, MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 22, 38-40 (1973) [hereinafter cited as *HEW Report*].

[4] Although this agency is presently known as the Department of Health and Human Services, references within the text will be to its former title, the Department of Health, Education and Welfare, since the titles of the materials cited refer to the latter.

[5] HEW REPORT, *supra* note 3, at 91. This study was one of the first national examinations of the medical malpractice insurance crisis by members of the bar, medical societies, and the public.

The Commission, at the conclusion of the fact finding reports, offered alternatives to litigation for doctors and attorneys. In addition to arbitration of claims, medical malpractice screening panels were designed to "allow an allegation of malpractice based on substantial merit to be settled by the insured without the necessity for the claimant to proceed to an action at law." *Id.*

See also Carter v. Sparkman, 335 So.2d 802 (Fla. 1976); Comiskey v. Arlen, 55 A.D.2d 304, 390 N.Y.S.2d 122 (App. Div. 1976).

[6] HEW REPORT, *supra* note 3, at 35 and 89.

policyholder during that same period.[7] The carriers attribute these disproportionate increases to the fact that the medical profession is subject to more nuisance claims[8] or unjustified claims and exhorbitant jury awards than are other professions.[9]

Medical professionals have reacted in a variety of ways to this problem, including threats to curtail medical services[10] and to retreat to a practice of medicine that would involve an assumption of all risks by the patient.[11] The most universal response, however, has been to pass on to patients the spiraling costs of insurance premiums in the form of higher health care costs.[12]

In an effort to reduce the drastic financial losses caused by the higher premium costs, members of the medical profession pressured state legislatures to develop a system to screen out excessive malpractice claims.[13] They

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[7] *See* HEW REPORT, *supra* note 3, at 637-43.

TABLE VII

MALPRACTICE INSURANCE RATES FOR LAWYERS, ARCHITECTS ENGINEERS; PHYSICIANS, SURGEONS, AND DENTISTS SHOWN AS PERCENTAGES OF 1962 RATES FOR EACH PROFESSION

	Lawyers	Architects/ Engineers	Physicians	Surgeons	Dentists
1962	100%	100%	100%	100%	100%
1964	99.0%	109.4%	115.8%	135.5%	100.3%
1966	106.9	109.4	134.0	157.1	115.9
1968	109.8	181.4	217.6	204.2	121.0
1970	170.7	300.3	540.0	673.9	164.4
1972	*	439.3	667.7	826.7	177.8

Id. at 643.

[8] HEW REPORT, *supra* note 3, at 91. *See also,* Curran, *Medical Malpractice: A Flood of Litigation*, 293 NEW ENG. J. MED. 1182, 1183 (1975).

[9] *Recent Medical Malpractice Legislation—A First Checkup*, 50 TUL. L. REV. 655, 656 (1976).

[10] MALPRACTICE INSURANCE CRISIS, *supra* note 1, at 24. *See also* Butler, *Malpractice Insurance—A Crisis in Medicine,* 123 WEST. J. MED. 328, 330 (1975). This article discusses the effects of efforts by anaesthesiologists in San Francisco, California to organize and initiate a "walk-out" of medical professionals designed to place pressure on state legislators to enact short- and long-term solutions to rising medical malpractice insurance premiums.

[11] BUTLER, *supra* note 10.

[12] Blaut, *The Medical Malpractice Crisis—Its Cause and Future,* 44 INS. COUNSEL J. 114, 115 n.12 (1977).

> From 1967 through January 1972 the health care components of the Consumer Price Index increased 67.1% for the Daily Hospital Service Charge, and 32.3% for the Physicians fee. . . Inflation accounted for 47% of the increase in doctor's bills, population growth accounted for the remaining 36%. Approximately 50% of the daily cost for each hospital patient and 20¢ to 50¢ out of every $10.00 fee a patient pays to a physician goes to pay for malpractice insurance.

[13] BUTLER, *supra* note 10, at 329. The physicians considered staging "walkouts" in order to draw attention to their problems. *Id.* They also threatened to practice "negative defensive medicine," that

hoped that by reducing specious malpractice claims, rising health care costs would drop proportionately. One proposed solution, adopted by twenty-six states within a three-year period, was the implementation of medical malpractice screening panels into the legal process.[14] In the twenty-six states which have implemented medical malpractice screening panels, the panels have been adopted pursuant to statutory law except in New Jersey where the panels have been adopted by court rule.[15] Basically, medical malpractice panels exist to screen out frivolous claims, encourage early settlements, and serve as an inexpensive alternative to costly litigation.

There is no uniform model for screening panels; however, four basic types of screening panel procedures can be identified.[16] They fall into groups which have been labeled according to submission prerequisites and admissibility of the panels' decisions into subsequent court proceedings:

(1) Mandatory and inadmissible;
(2) Mandatory and admissible;
(3) Voluntary and inadmissible; and,
(4) Voluntary and admissible.[17]

Panels may be conducted formally or informally. Formal panels are conducted like other adversarial hearings using sworn witnesses and traditional evidentiary rules. Panels usually consist of jurists, lawyers, and physicians.

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is, to refuse to undertake certain activities or procedures which carry a "high potentiality of suit." BLAUT, *supra* note 1, at 115. As a result, the patient in need of medical attention is compelled to assume the risks, both medical and economic, of treatment. *Id.*

[14] ALASKA STAT. §§ 09.55.535 to .536 (Supp. 1979); ARIZ. REV. STAT. ANN. § 12-567 (Supp. 1979); ARK. STAT. ANN. § 34-2602 to -2612 (Supp. 1979); DEL. CODE ANN. tit. 18, §§ 6803-14 (Supp. 1978); FLA. STAT. ANN. §§ 768.133 to .134 (West Cum. Supp. 1978); HAWAII REV. STAT. § 671-20 (Supp. 1979); IDAHO CODE §§ 6-1001 to -1013 (1979); IND. CODE ANN. § 16-9.5-9-1 to .5-9-10 (Burns Cum. Supp. 1979); KAN. STAT. ANN. §§ 65-4901 to -4908 (Supp. 1979); LA. CIV. CODE ANN. § 40:1299.47 (West 1979); ME. REV. STAT. ANN. tit. 24, §§ 2801-2809 (Supp. 1978); MD. CTS. & JUD. PROC. CODE ANN. §§ 3-2A-01 to -09 (1979); MASS. ANN. LAWS ch. 231, §§ 60B-60E (Michie/Law Co-op. Cum. Supp. 1981); MO. ANN. STAT. § 538.010 to .080 (Vernon Supp. 1979); MONT. REV. CODE ANN. §§ 17-1301 to -1315 (1979); NEB. REV. STAT. §§ 44-2840 to -2847 (1978); NEV. REV. STAT. § 41A:010-.095 (1975); N.H. REV. STAT. ANN. §§ 519-A:1 to -A:10 (1974); N.M. STAT. ANN. §§ 41-5-1 to -5-28 (Supp. 1978); N.Y. JUD. LAW § 148-a (McKinney Supp. 1979); N.D. CENT. CODE § 32-29.1-01 to .1-10 (1979); R.I. GEN. LAWS §§ 10-19-1 to -19-10 (Cum. Supp. 1978); TENN. CODE ANN. §§ 23-3401 to -3421 (Supp. 1979); VT. STAT. ANN tit. 12, §§ 7001 to 7008 (Supp. 1979); VA. CODE §§ 8.01-581.1 to -581.18 (Supp. 1979); WIS. STAT. ANN. §§ 655.02 to .21 (Special Pamphlet 1979).

This list has undergone great change as a result of state legislatures either enacting or repealing panel acts, or courts holding provisions of the entire procedure unconstitutional. New Jersey is the only state that has created medical malpractice screening panels by court rule. N.J. CT. R. 4:21 (1981).

[15] N.J. CT. R. 4:21-1 to -7 (1980).

[16] *The Constitutional Considerations of Medical Malpractice Screening Panels*, 27 AM. U. L. REV. 161, 164 (1977).

[17] *Id.*

Malpractice screening panels were originally suggested by HEW in a 1973 report[18] as an alternative to litigation. The HEW report recommended that the submission of claims to such panels be voluntary,[19] and that such submissions could occur either before or after the suit had been filed.[20] However, after enactment, many states transformed submission before panels into a mandatory procedure as a prerequisite to filing a law suit.[21] This, of course, changed the character of the proceedings and raised questions as to procedures and the weight of the panels' decisions.

Contrary to widespread expectations, malpractice screening panels have done very little to curb the growing rates of insurance premiums. Professor William Curran, a professor of legal medicine at Harvard, attacked the constitutionality of the panels early in their implementation and characterized them as "panic" legislation.[22] Indeed, Professor Curran's questioning of the panels' constitutionality is shared by plaintiffs who repeatedly assert that they are being deprived of their constitutional rights of equal protection and due process.[23] A majority of courts, however, have not shared Professor Curran's conclusions, and have upheld the implementation of medical malpractice screening panels as constitutional.[24] These courts are beginning to re-evaluate their tolerance of

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[18] *See* HEW REPORT, *supra* note 3, at 38-40.

[19] *Id.* at 91.

[20] *Id.*

[21] Such mandatory submission requirements were at one time found in all of the following states: Alaska, Arizona, Delaware, Florida, Hawaii, Indiana, Louisiana, Maryland, Missouri, Montana, Nevada, New Mexico, North Dakota, Pennsylvania, Rhode Island, Tennessee, and Virginia. *See supra* note 14. New Jersey has accomplished the same by Supreme Court rule. N.J. CT. R. 4:21 (1981).

[22] CURRAN, *supra* note 1, at 24.

[23] *See, e.g.*, Davison v. Sinai Hosp. of Baltimore, 671 F.2d 361 (4th Cir. 1980); Soricelli v. Baker, 610 F.2d 131 (3d Cir. 1979); Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980); Aldana v. Holub, 381 So.2d 231 (Fla. 1980); Parker v. Children's Hosp. of Philadelphia, 483 Pa. 106, 394 A.2d 932 (1978); Attorney General v. Johnson, 282 Md. 274, 385 A.2d 57 (1978); State ex rel. Strykowski v. Wilkie, 81 Wis. 2d 491, 261 N.W.2d 434 (1978); Everett v. Goldman, 359 So.2d 1256 (1978); Paro v. Longwood Hosp., 373 Mass. 639, 369 N.E.2d 985 (1977); Graley v. Sayatham, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (C.P. 1976); Simon v. St. Elizabeth Hosp., 3 Ohio St. 3d 164, 355 N.E.2d 903 (1976); Wright v. DuPage Hosp. Ass'n., 63 Ill. 2d 313, 347 N.E.2d 736 (1976); Carter v. Sparkman, 335 So.2d 802 (Fla. 1976).

[24] Such decisions for the most part follow the rationale used by the Florida Supreme Court in Carter v. Sparkman, 335 So.2d 802 (Fla. 1976):

> At the time of enactment of the legislation in question *sub judice*, there was an imminent danger that a drastic curtailment in the availability of health care services would occur in this state. The Legislature's recognition of the crisis in the area of medical care and the need for legislation for the benefit of public health in this state is evidenced by the Preamble to Chapter 75-9, Laws of Florida,. . . .
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> Even though the pre-litigation burden cast upon the claimant reaches the outer limits of constitutional tolerance, we do not deem it sufficient to void the medical malpractice law.

Id. at 806-807.

screening panels, however, as they witness the reality of the dismal failure of the screening panels and the intolerable deprivation of the litigants' constitutional rights.[25]

Screening panels, once viewed as a shining answer to the malpractice crisis, are now only a dark victory.

This article explores cases which have raised constitutional arguments and includes several recent developments which have shown that panels do not aid the malpractice crisis, but may in fact further exacerbate it. In addition, the article examines New Jersey Court Rules 4:21-1 to 4:21-7[26] and conveys the authors' belief that the New Jersey Supreme Court exceeded its rulemaking authority when it adopted a substantive law more appropriately left to the discretion of the Senate and the Assembly.

The New Jersey Court Rule

The New Jersey Supreme Court became involved in the concept of professional liability panels for medical malpractice cases in 1960, when it appointed the Committee on Expert Medical Testimony.[27] However, the Supreme Court took no action on the Committee's report at that time. In 1962, the Committee, now called the Committee on Impartial Medical Experts, re-examined the problem of medical malpractice cases and recommended the establishment of panels to evaluate claims.[28] Finally, in 1965, the recommendations of the renamed Committee on Relations with the Medical Professions were adopted as Rule 4:25B.[29] The stated purpose of the rule was to discourage frivolous cases and to make expert testimony available to claimants where there was a reasonable basis for the claim.[30] Submission of the claim to the panel for hearing was voluntary and all proceedings and recommendations were confidential and could not be used in any other proceedings without the consent of all parties.[31] A plaintiff could be bound by a panel's adverse determination if the plaintiff had previously consented to be so bound.[32] The proceedings

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[25] *See, e.g.*, GAGLIARDI, CHMN, REPORT OF THE AD HOC COMMITTEE ON MEDICAL MALPRACTICE PANELS TO THE CHIEF ADMINISTRATIVE JUDGE OF THE STATE OF NEW YORK ON THE OPERATION OF MEDICAL MALPRACTICE PANELS 165-66 (March 1980) [hereinafter cited as the *Gagliardi Report*]. For a detailed discussion of this report, *see* this text, "Recent Developments," *infra*. *See also* Aldana v. Holub, 381 So.2d 231 (Fla. 1980); Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980).

[26] N.J. CT. R. 4:21-1 to -7 (1980).

[27] Marsello v. Barnett, 50 N.J. 577, 236 A.2d 869 (1961).

[28] *Id.* at 583, 236 A.2d at 872.

[29] N.J. CT. R. 4:25B became R. 4:21 in the 1961 rules' revision.

[30] 50 N.J. at 585, 236 A.2d at 873. The panels were viewed as a way of overcoming the "conspiracy of silence" imposed by the medical profession upon itself and which made it virtually impossible to find medical experts to testify at trial.

[31] *Id.*

[32] Grove v. Seltzer, 56 N.J. 321, 266 A.2d 301 (1970).

were informal. The panel determined whether there was a reasonable basis for the claim, but was not empowered to give an opinion as the extent of damages.

Statistics maintained on medical malpractice cases indicated that between 1966 and 1977, only 405 requests for panel hearings were filed and, of that number, only 173 were actually heard by a panel.[33] During this same period, it was estimated that between 500 and 800 medical malpractice actions were initiated each year.[34] The panels consistently found for the defendant; the rate of decisions of "no reasonable basis" ranged from a low of 67% to a high of 93%.[35] One reason suggested for the incongruity in findings is that only relatively inexperienced plaintiffs' attorneys were using the panels to screen cases of questionable merit.[36]

Based on this poor experience with Rule 4:25B (amended to Rule 4:21 in September 1969),[37] the Committee on Relations with the Medical Profession concluded that the old rule was totally ineffective because it had completely failed to serve the purpose for which it was adopted.[38] The Committee recommended to the Supreme Court that a mandatory procedure be adopted instead and proposed a rule based in large part on the New York statute.[39] A minority report was also filed which dissented only from the proposal to have a unanimous panel decision admissible into evidence in a subsequent trial.[40]

The stated purpose of the rule was to discourage baseless claims and to make expert testimony available to claimants where they demonstrated a reasonable basis for their claims. The rule provided for the designation of a judge in each vicinage to pre-try all medical malpractice cases[41] and to preside at panel hearings (but not at the trial.)[42] The judge was also charged with the responsibility of scheduling a pre-trial conference within one year of the filing of the action.[43] If the presiding judge thought it appropriate, he could include in the pre-trial order a provision for submission of the claim to a medical malpractice panel.[44] Another change in the new rule was to reduce the size of the panel from five members to three,

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[33] 101 N.J.L.J. 451 (1978).

[34] INSTITUTE OF JUDICIAL ADMINISTRATION, MEDICAL MALPRACTICE PANELS IN FOUR STATES (1977).

[35] *Id.*

[36] *Id.*

[37] *See Grove, supra* note 32.

[38] 101 N.J.L.J. 451 (1978).

[39] *Id. See also* discussion, *infra* this text concerning the New York statute.

[40] 101 N.J.L.J. 451 (1978).

[41] N.J. CT. R. 4:21-2(b) (1980).

[42] *Id.* 4:21-2(c).

[43] *Id.*

[44] *Id.* 4:21-2(a) and -2(d).

including a doctor, an attorney, and the pre-trial judge.[45] The rule made no change as to the informal nature of the proceedings and retained the practice that no records or other transcripts be made.[46] Upon stipulation of all of the parties, the panel's jurisdiction could be extended to determine damages.[47] If the vote of the panel was unanimous, the order setting forth the disposition of the case would become admissible into evidence at any subsequent trial, and would be accorded such weight as the trier of facts would choose to give it.[48]

Rule 4:21-5 was amended, effective September 1979.[49] As a result, the rule now exempts from panel submission those cases which turn only on witness credibility and not on the applicable standard of medical care or its alleged violation.[50] Rule 4:21-5, as amended, affords the presiding judge subpoena power[51] and allows the doctor member of the panel to be called as a witness at a subsequent trial.[52]

Many states have activated medical malpractice panels by statute; New Jersey has done so by court rule.[53] When the court has virtually

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[45] *Id.* 4:21-4(a).

[46] *Id.* 4:21-5(a).

[47] *Id.* 4:21-5(c).

[48] *Id.* 4:21-5(e). The approach to medical malpractice litigation embodied in Rules 4:21-1 to -5 has been attacked as unconstitutional in Suchit v. Baxt, 176 N.J. Super. 407, 423 A.2d 670 (Law Div. 1980). In that case, the plaintiff argued that the provision in Rule 4:21-5(e) permitting use of the malpractice panel's findings in a subsequent trial violated, *inter alia,* her right to cross-examine witnesses. The court upheld the constitutionality of N.J. CT. R. 4:21-1 to -5 on several grounds, one of which was the fact that the rule itself provided sufficient protections against the misuse of information provided to the malpractice panel. *Id.* at 414, 423 A.2d at 674.

[49] The 1979 amendment was designed to answer certain questions raised during the first year of this new rule. *See* PRESSLER, CURRENT N.J. COURT RULES, R. 4:21, comment 1 at 634 (1980).

[50] N.J. CT. R. 4:21-2(d) (1980).

[51] *Id.* 4:21-5(b).

[52] *Id.* 4:21-5(d).

[53] An examination of the rulemaking power of the New Jersey Supreme Court is warranted at this juncture. The Supreme Court's power is derived, in part, from the New Jersey Constitution of 1947, Article VI, Section 2, Paragraph 3, which provides that [t]he Supreme Court shall make rules governing the administration of all courts in the state, and subject to law, the practice and procedure in all such courts.

The case of Winberry v. Salisbury, 5 N.J. 240, 74 A.2d 406 (1950), addressed the question of whether a statute which permitted an appeal within one year of judgment could prevail over a subsequent Supreme Court rule which required such an appeal to be taken within forty-five days. The New Jersey Supreme Court interpreted the phrase "subject to law" found in the New Jersey Constitution to mean that "the rulemaking power of the Supreme Court is not subject to overriding legislation, but is confined to practice, procedure and administration as such." *Id.* at 255, 74 A.2d at 414. As a result, any legislation dealing with procedure could be held unconstitutional, whether or not it conflicted with a Supreme Court rule. *See* Note, *The Rule-Making Power: Subject to Law?* 5 RUTGERS L. REV. 376, 383 (1950).

The Court's decision in *Winberry* created a crisis concerning the adoption of the Rules of Evidence for New Jersey's courts. Who was to enact them: the courts or the Legislature? Based upon the *Winberry* decision, the only possible solution was to have all three branches of government

unlimited powers to adopt rules, however, the danger exists that that same court will be called upon to decide its constitutionality. Obviously, if the court could not justify the rule on administrative or procedural grounds, it would not have enacted the rule in the first place, but two important aspects of government—separation of powers and the system of checks and balances—have been seriously eroded by giving the courts such broad power. Dean Pound of Harvard Law School, however, contends that broad rulemaking power is a good idea since, if the rules do not work well, they can be changed immediately without having to wait for the painfully slow legislative repeal process to run its course.[54] But, it should be noted that it took the New Jersey Supreme Court eleven years to realize that former Rule 4:25B was ineffective before it adopted Rule 4:21.

Equal Protection

The issue of equal protection has been raised repeatedly by non-physician claimants in malpractice cases because of the added requirements imposed upon them in the litigation of their claims, as opposed to all other tort victims of malpractice acts.[55] A non-physician claimant who brings a claim, crossclaim, or counterclaim against a physician[56] is re-

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participate in the enactment of the Rules. The result was the enactment of the Evidence Act of 1960 which fixed some rules by statute while others were prepared by the court and filed with the Legislature, to become effective unless disapproved by a joint resolution signed by the Governor.

It became increasingly difficult for the Court to separate procedure from substance since procedural issues carried the potential for substantive ramifications. *See generally* 5 RUTGERS L. REV. 376. Finally, in Busik v. Levine, 63 N.J. 351, 307 A.2d 571 (1973), Chief Justice Weintraub, writing for the plurality, rejected the rigid substance-procedure dichotomy, finding that "[a] rule of procedure may have an impact upon the substantive result and be no less a rule of procedure on that account." *Id.* at 364, 307 A.2d at 578. Thus, instead of narrowing the category of practice and procedure, the Court considerably broadened it.

The rulemaking powers of the court were further broadened in State v. Leonardis, 73 N.J. 360, 375 A.2d 607 (1977), wherein the court considered the constitutionality of Rule 3:28 which concerns Pre-Trial Intervention (PTI). In a previous appeal, the court held that PTI was a procedural device, and therefore within the rulemaking authority of the court. On appeal to the Supreme Court, the Court held that an "absolute prohibition against rules which merely affect substantive rights or liabilities" such as Rule 3:28 "would seriously cripple the authority and concommitant responsibility which have been given to the Court by the Constitution." 73 N.J. at 374, 375 A.2d at 614. Justice Pashman warned, however, that the *Winberry* rule prohibited the Court from making substantive law through the rulemaking power. *Id.* Nothing in *Leonardis* indicated that the Legislature would be foreclosed from enacting legislation affecting the substantive aspects of PTI. *Id.*

[54] Pound, *Procedure under Rules of Court in New Jersey*, 66 HARV. L. REV. 28, 46 (1952).

[55] Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEXAS L. REV. 759, 769-84 (1977).

[56] *See* N.J. CT. R. 4:21-1 and -2(a). The New Jersey rule is used merely to illustrate the limited scope of the panel's pre-trial procedure which applies only to physicians and to no other professional persons.

quired to bring the action to a malpractice screening panel before proceeding to trial court, in those states which have such panels.[57]

As in other cases which involve a determination of whether a plaintiff is denied equal protection of the law, the court must first determine the proper standard of judicial scrutiny to be applied, and then examine the particular facts of the case in order to balance the rights alleged to be violated against the legislative interest sought.[58] This section will discuss various decisions on the constitutionality of malpractice panels under equal protection analysis.

In *Carter v. Sparkman*,[59] plaintiffs, against whom charges of malpractice had been leveled, challenged section 768.134(2) of the Florida Malpractice Act.[60] Plaintiffs contended that this section created an impermissible classification within the entire class of malpractice litigants because it required that complainants appear before screening panels prior to filing suit, but remained silent as to whether the defending physician could also appear. The court interpreted the statute to mean that if a physician failed to appear before the screening panel after the plaintiff had done so, that fact would be admissible into evidence in any subsequent trial.[61]

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[57] This condition precedent, that a panel hearing take place before the complaint is brought before a state court, is not uniform in those states which have screening panels. *See supra*, note 13. Those states which have adopted it are Arkansas, Florida, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Nevada, New York, Ohio, Pennsylvania, Tennessee, and Wisconsin.

[58] Whether or not the disputed statute, which creates a special class, violates the Equal Protection clause depends on whether the class comes under traditional groupings which have been held offensive to the Constitution. *See generally* TRIBE, AMERICAN CONSTITUTIONAL LAW at 992-93 (1978). Such groupings correspond to levels of judicial scrutiny which have been referred to as tiered scrutiny on three levels, or two traditional levels and a new intermediate level. GUNTHER, CONSTITUTIONAL LAW at 658 (9th ed. 1975).

The first level, or tier, involves application of the rational basis test. *See id.* at 658. Under this test, the state must show a rational relationship between the class created by the statute and the statute's intent. The focus is on "economic and sound legislation," *id.* at 658, which carries with it a strong presumption of constitutionality. Gunther, *Forward: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection,* 86 HARV. L. REV. 1, 8 (1972).

Under second tier scrutiny, statutes that fall within certain legislative and administrative classifications are held unconstitutional "absent a compelling governmental justification if they disturb benefits or burdens in a manner inconsistent with fundamental rights." TRIBE at 1002. The presumption of constitutionality is inverted on the second tier level; the burden is on the state to justify such an interest. 86 HARV. L. REV. at 8.

The Burger Court, however, has modified the two tier approach. GUNTHER, CONSTITUTIONAL LAW at 663. Concerned about the rigidity of the two tier approach, yet unwilling to expand the scope of the new equal protection, the Court introduced an intermediate tier which it labeled intermediate scrutiny, or "rational basis with bite." *Id.* at 662; TRIBE at 1082. Cases which arise under this intermediate tier involve classifications which are close to being suspect. A common example of cases in this area involve women.

[59] 335 So.2d 802 (Fla. 1976).

[60] FLA. STAT. ANN. §§ 768.133 to .134 (West Supp. 1978).

[61] *See* Carter v. Sparkman, 335 So.2d 802 (Fla. 1976).

The court conceded that the state's act approached "the outer limits of constitutional tolerance," but upheld the constitutionality of the act under the first tier rational basis test.[62] The court concluded that such a procedure would aid the public in continued health care because it would discourage frivolous claims, thereby reducing malpractice premiums.[63]

A year after the *Carter* decision, the Louisiana Supreme Court similarly upheld as constitutional under the rational basis test its screening panel procedures. In *Everett v. Goldman*,[64] plaintiffs asserted that the screening panel procedure violated their fundamental right of immediately commencing a malpractice suit without panel determination.[65] The court rejected plaintiffs' contention that a fundamental right was involved, and held that there was a rational relationship between the procedure and the state's interest in lowering health care costs and assuring medical care for Louisiana citizens.[66]

Subsequent to the Louisiana Supreme Court ruling, a plaintiff in Massachusetts challenged that state's screening panel act.[67] At issue was section 60B of the Massachusetts statute which states that all actions for medical malpractice must be heard before a state tribunal within fifteen days of the filing of defendant's answer.[68] The "tribunal" would be required to determine whether a "legitimate question of liability has been made that is appropriate for judicial inquiry."[69] If the panel found for the defendant, "the judge member of the tribunal would be required to impose a bond on the plaintiff as a condition for further prosecution."[70] The bond would be payable to the defendant for his costs if he prevails. The maximum amount of the bond was set at $2000.00, but the amount

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[62] *Id.* at 806.

[63] In *Carter*, the court stated that

> [t]he Legislature felt it incumbent upon itself to attempt to resolve the crisis through exercise of the police power for the general health and welfare of the citizens of this State and accordingly enacted Chapters 75-9, Laws of Florida, to effectuate that purpose. The statutes involved here deal with matters related directly to public health and obviously have for their purpose an effort to have the parties mediate claims for malpractice thereby reducing the cost of medical malpractice insurance and ultimately medical expenses.

335 So.2d at 806.

[64] 359 So.2d 1256 (La. 1978). Plaintiffs allege that they are denied equal protection because as malpractice victims (unlike other tort victims), they are forced to convene panels as a condition precedent to litigation, and may not set out in their petitions specific damage amounts. Plaintiffs urge the court to view such a deprivation as a denial of fundamental rights. The court rejects this contention, and plaintiffs' argument that they are part of a suspect classification. *Id.* at 1265.

[65] *Id.* 1265-66.

[66] *Id.* at 1266.

[67] Paro v. Longwood Hospital, 373 Mass. 645, 369 N.E.2d 985 (1977).

[68] MASS. GEN. LAWS ANN. ch. 231, § 60B (Supp. 1976); *see also* Note, *The Massachusetts Medical Malpractice Statute: A Constitutional Perspective*, 11 SUFFOLK L. REV. 1289 (1977).

[69] 373 Mass. at 648, 369 N.E.2d at 987.

[70] *Id.*

could be lowered for indigent persons at the judge's discretion.[71] The plaintiff contended that such requirements violated his right of equal protection under the Commonwealth's Constitution and the Federal Constitution.

The Massachusetts court *sua sponte* determined that the rational basis test was the proper level of scrutiny to be applied, and upheld the constitutionality of the procedure. The Massachusetts court explained that the selection of the rational basis test was necessary with respect to this statute in order to guarantee the availability of malpractice insurance in the state.[72] This decision appeased the state's malpractice carriers who had threatened to stop selling malpractice insurance in the state unless the number of claims were reduced.

The preceding three cases are representative of an early line of decisions that upheld screening panels as constitutional. In each case, the court applied the rational basis test to insure that medical services to the public would not be jeopardized. The courts confronted each case with little empirical data upon which to base their decisions; no significant studies of the panels' success or failure rates or the effect of the panels on premium rates were available to the litigants or the courts.

A second line of decisions emerged which began to question the existence of the "crisis" itself and the viability of panels to cure such a complex problem. The Idaho Supreme Court, relying on *Reed v. Reed*,[73] chose the middle tier scrutiny test as the proper level of analysis:

> It is our opinion that this poses a different and higher standard than the traditional restrained analysis of equal protection. The standard set forth in *Reed* focuses upon the relationship between the subject legislation and the object or purpose to be served thereby. . . . It is enough to say at this juncture that with respect to certain statutes which create obviously discriminatory classifications, this Court will examine the means by which those classifications are utilized and implemented in light of the asserted legislative purpose.[74]

Jones v. State Board of Medicine comes to the Idaho court on an action for declaratory judgment brought by physicians and hospitals. The district court's decision being appealed here declared medical malpractice panels unconstitutional and used the test of "a reasonable relationship to the objectives sought to be advanced by the act."

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[71] *Id.*

[72] *Id.*

[73] 404 U.S. 71 (1971) (mother sought right to administer estate in Idaho where statute gave preference to men over women; statute held unconstitutional since the statutory preference for men had no substantial relation to the purpose of the legislation).

[74] Jones v. State Board of Medicine, 97 Idaho 859, 867, 555 P.2d 399, 407 (1976).

The Idaho Supreme Court disagreed with the analysis of the Idaho trial court and found it necessary to look beyond minimal scrutiny. The court concluded that no decision could be made on the equal protection argument because of a lack of factual information bearing on the issue raised on appeal.[75]

The court suggested that the use of the intermediate scrutiny test "focuses attention on the means-ends effect" of the Idaho act.[76] In its decision, the court weighed three issues:

> (1) Whether the act was designed to insure continued health care to citizens;
>
> (2) Whether limiting the amount of recovery would allow for an accurate estimate of losses and thereby encourage more insurance companies to enter the market because of increased stability; and,
>
> (3) Whether this would be a proper response to Idaho's medical malpractice "crisis."

The court ultimately concluded that insufficient evidence was produced to substantiate the means-end justification on all of the above issues.[77] The court by way of *dicta,* stated that "it is apparent from the fact of the Act that the discriminatory classification is created based on the degree of injury and the damage suffered as a result of medical malpractice."[78]

Subsequent to *Jones,* the Court of Common Pleas of Ohio[79] also chose the middle tier scrutiny as the proper standard for review of the state's malpractice act. The Ohio malpractice act[80] required that litigants list collateral benefits in the civil complaint and deduct certain collateral benefits from the medical claim award.[81] Because these procedures were not required by any other tort litigant in Ohio, the malpractice act created a separate class of litigants.[82]

The Ohio court rejected defendant's theory that the Ohio act ensured that health care to the public would continue.[83] The court held that there was "no satisfactory reason for this separate and unequal treatment."[84] To put to rest any doubt about the court's analysis, the court explained:

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[75] *Id.* at 870, 555 P.2d at 414.
[76] *Id.* at 876, 555 P.2d at 417.
[77] *Id.* at 871, 555 P.2d at 414.
[78] *Id.*
[79] Graley v. Satayatham, 74 Ohio Op. 2d 316, 343 N.E.2d 832 (C.P. 1976).
[80] OHIO REV. CODE ANN. §§ 2305.27, 2307.42 and 2307.43 (1977).
[81] *Id.* § 2305.27.
[82] 74 Ohio Op. 2d 316, 319, 343 N.E.2d 832, 836 (C.P. 1976).
[83] *Id.* at 320, 343 N.E.2d at 838.
[84] *Id.*, 343 N.E.2d at 837.

> There obviously is no "compelling governmental interest" unless it be argued that any segment of the public in financial distress be at least partly relieved of financial accountability for its negligence. To articulate the requirement is to demonstrate its absurdity, for at one time or another every type of profession or business undergoes difficult times and it is not the business of government to manipulate the law so as to provide succor to one class, the medical, by depriving another, the malpracticed patients, of the equal protection mandated by the constitution.[85]

The preceding two cases signal a shift in judicial analysis from the traditional first tier rational basis level to intermediate scrutiny of malpractice screening panels. With statistical studies on the performance of panels now available, the ineffectiveness of the panels has been demonstrated. Panels in many states fail to meet the original purpose of the acts.

Through the application of intermediate scrutiny, the courts may be able to prove that no affirmative relation exists between the means—the panels themselves, and the end—the goals of reducing high premiums and insuring health care service. The right of compensation for bodily injury is arguably of great significance, and while not a fundamental right, it should be given more deference by the courts than that of mere rational basis.[86]

While it is the authors' contention that the selection of middle tier scrutiny is correct, the probability of defeating malpractice panel legislation under this theory is highly unlikely. The authors urge that greater emphasis be placed on the due process rights being protected, and view such a challenge as provoking the inevitable doom of malpractice panels.

Due Process

The theory which has proven most successful for litigants challenging the constitutionality of the various state malpractice acts has been that such acts deprive litigants of due process as guaranteed by the Fifth and Fourteenth Amendments to the Constitution. While the due process challenge is sufficient unto itself as a meritorious theory, it is often coupled with the assertion that the right to trial by jury has been denied. This latter theory will be discussed in another section of this article.

Recent decisions by courts which have declared that malpractice acts are unconstitutional[87] have been based on the theory that the acts violate

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[85] *Id.*

[86] *See* REDISH, *supra* note 55 at 774.

[87] Aldana v. Holub, 381 So.2d 231 (Fla. 1980); Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980).

notions of fundamental fairness,[88] or procedural due process.[89] Following is a discussion of five cases which illustrate this theory. For the most part, these cases are based on the denial of three procedural due process rights, *viz:*

(1) Abrogation of existing common law rights without making available a reasonable legal substitute;

(2) Imposition of a limited recovery provision in some state statutes; and,

(3) Access to courts.[90]

The Illinois Supreme Court in *Wright v. Central DuPage Hospital Ass'n*[91] entertained arguments which alleged abrogation of existing common law rights (number (1), *supra)* and imposition of a limited recovery provision (number (2), *supra).* Plaintiffs alleged that the Illinois statute, which denied recovery for losses and damages in excess of $500,000.00,[92] was arbitrary and unreasonable. Plaintiffs argued that this limit discriminated not only between non-medical malpractice litigants and medical malpractice litigants, but also against all injured medical malpractice patients. The court agreed with the plaintiffs, and held that the statute violated the Illinois Constitution.[93] Additionally, plaintiffs asserted that the limitation on recovery abrogated their common law right of recovery equivalent to injury or loss without providing them with a reasonable legal substitute.[94]

Defendants, on the other hand, asserted that the limitation provision was no different from that found in the state's workers' compensation and wrongful death statutes. They argued that such provisions have been enacted for the public good. While defendants recognized that some malpractice victims would be hurt by a reduction in their anticipated recovery, this would be more than offset by lower insurance premiums and lower medical costs for all recipients of medical care.

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[88] *See generally* TRIBE, AMERICAN CONSTITUTIONAL LAW 992-93 (1978).

[89] *See, e.g.,* Aldana v. Holub, 381 So.2d 231 (Fla. 1980).

[90] *See, e.g.,* Wright v. Central DuPage Hospital Ass'n, 63 Ill. 2d 313, 347 N.E.2d 736 (1976); Comiskey v. Arlen, 55 A.D.2d 304, 390 N.Y.S.2d 122 (App. Div. 1976); Wisconsin ex rel. Strykowski v. Wilkie, 81 Wis.2d 491, 261 N.W.2d 434 (1978).

[91] 63 Ill. 2d 313, 347 N.E.2d 736 (1976).

[92] WIS. STAT. ANN. § 655.27(6) (1975). This ceiling applies to non-medical expenses. *See* Mathy, *Testing the Constitutionality of Medical Malpractice Legislation: The Wisconsin Medical Malpractice Act of 1975*, 1977 WIS. L. REV. 838, 844 n.37 (1977).

[93] 63 Ill. 2d at 329, 347 N.E.2d at 743.

[94] *See* REDISH, *supra* note 55 at 784: "The primary concern is that by denying plaintiffs the full amount of their damages, recovery and liability limits violate concepts of substantive due process."

The court found no merit in this argument.[95] Although it found that it had the power to reform societal problems "one step at a time,"[96] the court was unwilling to apply this power in a case such as that which involved an arbitrary solution.[97] The Illinois Court held that the section of the malpractice statute which limited recovery was arbitrary and capricious, and therefore unconstitutional on due process grounds.[98]

In *Jones v. State Board of Medicine*,[99] the State Board of Medicine and the State Department of Health and Welfare (who are charged with hospital and physician licensing) appealed from a district court decision which held unconstitutional the Idaho malpractice act. Respondent-plaintiff physicians had argued below that the act operated to deny them their due process rights in three respects: that it deprived them of their constitutional right to pursue a recognized profession, that it limited medical malpractice actions without supplying a corresponding *quid pro quo*, and that the recovery provisions within the act were arbitrary, without a rational basis, and against public policy.[100]

Specifically at issue in *Jones* was section 6[101] of Idaho's malpractice act. Section 6 required physicians and hospitals to secure liability insurance as a precondition to practicing within the state. Respondents viewed this requirement as an arbitrary and unreasonable regulation. In its reversal of the lower court's decision, the Idaho Supreme Court decided that

> requiring doctors and hospitals to obtain licenses before practicing medicine or providing health care is clearly within the state's

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[95] *Id.* at 329, 347 N.E.2d at 742. At least nine other state malpractice acts had at one time placed limits on recoveries: CAL. CIV. CODE § 332.2 (West 1978) (maximum non-economic loss recovery of $250,000.00); FLA. STAT. § 768.54 (1975), repealed by 1976 Fla. Laws Ch. 768-168 § 3 (effective July 1, 1982); IDAHO CODE § 39-4204, 4205 (Supp. 1975) ($150,000.00); ILL. REV. STAT. ch. 70 § 101 (1975) ($500,000.00); IND. CODE ANN. § 16-9.5-2-2 (Burns Supp. 1975) ($500,000.00); LA. REV. STAT. ANN. § 40:1299.42 (West 1975) ($500,000.00); N.D. CENT. CODE § 26-40-11 (Supp. 1975) ($500,000.00); OHIO REV. CODE ANN. § 2307.43 (1975) ($200,000.00); WIS. STAT. § 655.27(6) (1975) ($500,000.00). 1977 WIS. L. REV. at 839 n.6.

[96] 63 Ill. 2d at 330, 347 N.E.2d at 743. *See also* Williamson v. Lee Optical of Oklahoma, Inc., 348 U.S. 483, 489 (1975).

[97] 63 Ill. 2d at 330, 347 N.E.2d at 743.

[98] *Id.*

[99] 97 Idaho 859, 555 P.2d 399 (1976).

[100] *Id.* at 869, 555 P.2d at 409.

[101] Idaho Code § 39-4206, section 6 provides:

> Every acute care hospital and physician licensed to provide health care in this state shall, as a condition of securing and maintaining such licensure, unless the requirement therefore has been waived as provided in section [11 of this act], secure liability insurance underwriting the exposure to loss referred to in sections [4 and 5 of this act (the physician or hospital liability limitation sections)] and shall file an appropriate certificate of insurance as hereinafter provided, confirming the existence of such insurance with at least such limits of liability at all times during which licensure remains valid. . . .

97 Idaho at 868, 555 P.2d at 408.

> police power. Here such licenses are required to be preconditioned upon obtaining medical malpractice insurance. . . . We hold that such requirements of obtaining medical malpractice insurance as a condition to licensure bear a rational relationship to the health and welfare of the citizens of the state by providing protection to patients who may be injured as a result of medical malpractice and to this extent does not violate the guarantees of due process of law.[102]

The court believed that the insurance requirement would result in a guarantee of full health care services for the public by lessening the likelihood that physicians, without insurance, would practice defensive medicine.

The physicians also argued the *quid pro quo* doctrine—that the Idaho act abolished a common law right without providing a reasonable substitute.[103] The court traced the history of the doctrine to its origin in *New York Central R.R. v. White*[104] which held that "no person has a vested interest in any rule of law entitling him to insist that it shall remain unchanged for his benefit."[105] The litigants drew a parallel between the societal good of workers' compensation and the goals of the malpractice screening panels. The Idaho Court held, however, that the entire theory was no more than a "make-weight argument."[106] The court refrained from deciding the physicians' third argument in which they challenged the act as being arbitrary. The court's rationale was that, due to a lack of facts on the evidentiary record about the nature of the "crisis," no cogent determination could be made. Therefore, the act was held not unconstitutional as a violation of due process rights in Idaho.

Two months after the decision in Idaho, the New York Supreme Court Appellate Division decided *Comiskey v. Arlen* in which the due process issue raised was a possible violation of access to courts.[107] In a parallel case in Wisconsin, *Wisconsin ex rel. Strykowski v. Wilkie*,[108] plaintiffs alleged that the statute imposed unconstitutional provisions:

> [T]he financial expense of the hearing, the special pleading process, a biased panel (two of the five panel members are health

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[102] *Id.*

[103] *Id.* at 864, 555 P.2d at 404.

[104] 243 U.S. 188 (1917) (upheld the constitutionality of workers' compensation laws).

[105] *Id.* at 198.

[106] 97 Idaho at 868, 555 P.2d at 409. The Idaho court concluded that the United States Supreme Court in *White* did not intend to engraft upon the traditional due process test an additional standard when the challenged statute involves alteration of some prior existing common law doctrine. *Id. See also* REDISH, *supra* note 55 at 788 for an in-depth analysis of common law rights and the *quid pro quo* doctrine.

[107] 55 A.D.2d 304, 390 N.Y.S.2d 122 (App. Div. 1976)

[108] 81 Wis.2d 491, 261 N.W.2d 434 (1978).

> providers) and the denial of the right to present all claims involved in a single proceeding.[109]

Yet, the Wisconsin court upheld the constitutionality of the statute:

> Whatever the precise status of the right of access to the courts, it is clear that due process is satisfied if the statutory procedures provide an opportunity to be heard in court at a meaningful time and in a meaningful manner. . . . Due process is flexible and requires only such procedural protections as the particular situation demands.[110]

The New York court, in deciding *Comiskey v. Arlen,* upheld the constitutionality of the New York statute for much the same reason. The New York statute provides for the convening of a panel after commencement of court proceedings.[111] New York had been greatly criticized because of this procedure, most notably in a special report compiled by New York jurists who concluded that the procedure was a failure.

In 1979, the Supreme Court of Missouri decided *State ex rel. Cardinal Glennon Memorial Hospital for Children v. Gaertner.*[112] The Missouri court approached the issue from a First Amendment point of view, as opposed to other jurisdictions which considered the issue to be one of alleged violations of access to court. Specifically, the appellees contended that chapter 538 of the Missouri statute,[113] which called for a mandatory submission of a medical malpractice claim to a review board, violated article I, section 14 of the Missouri Constitution which states that the "[r]ight of access to courts is explicitly preserved."[114]

The Missouri court cited *DeMay v. Liberty Foundry Co.*[115] as persuasive. *DeMay* held that the access to courts guarantee has been viewed as "an aspect of the right to petition the government contained in the First Amendment to the United States Constitution."[116]

In 1980, the first case which evinced a change in the way courts view malpractice act cases was decided in Florida. *Aldana v. Holub*[117] declared the state's malpractice act to be unconstitutional on procedural due

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[109] Comment, *Constitutional Challenges to Medical Malpractice Review Boards*, 46 TENN. L. REV. 607, 625 (1979).

[110] 81 Wis.2d at 512, 261 N.W.2d at 444.

[111] 55 A.D.2d at 305, 390 N.Y.S.2d at 123.

[112] 583 S.W.2d 107 (Mo. 1979).

[113] MO. ANN. STAT. § 538.010 to .080 (Vernon Supp. 1979).

[114] MO. CONST. art. I, § 14.

[115] State ex rel Cardinal Glennon Mem. Hosp. v. Gaertner, 583 S.W.2d 107, 111 (Mo. 1979), *citing* DeMay v. Liberty Foundry Co., 327 Mo. 495, 37 S.W.2d 640 (1931).

[116] 327 Mo. at 506, 37 S.W.2d at 645.

[117] 381 So.2d 231 (Fla. 1980).

process grounds.[118] Contained in the Florida Medical Mediation Act[119] was a special provision that mandated that a final hearing on the merits of a malpractice case be concluded within a ten-month period from the date of filing.[120] In *Aldana,* defendant-physician contended that this provision denied him his right to due process because his right to mediation had lapsed with the passage of the ten-month period. (At the end of the statutory period, the panel's judicial referee declared a mistrial and dismissed plaintiff-patient's claim without leaving open the possibility that another panel would be called in the future.[121]) The Florida court held that such jurisdictional time limits as the one contained in the Florida act are "intrinsically unfair, arbitrary and capricious in their application,"[122] and therefore violative of the physician's due process rights.

It is perhaps ironic that the Florida court was among the first to declare malpractice screening panels unconstitutional since this same court, only a few years earlier, went to great lengths to uphold the panels' constitutionality. While exercising care not to undermine the precedent established in the earlier case of *Carter v. Sparkman*,[123] the court concluded that in reality the panels were not working as once hoped, and that this failure contributed to the dilemma being experienced by defendant. The *Carter* court concluded that "[t]o now increase the prelitigation

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[118] *Id.* at 238.

[119] FLA. STAT. ANN. §§ 768.133 to .134 (West Cum. Supp. 1978).

[120] FLA. STAT. ANN. § 768.443 (West Cum. Supp. 1978); RULES OF MEDICAL MEDIATION PROCEDURE R. 20.190 provides as follows:

> Rule 20.190. Termination
>
> The clerk shall send to all parties a notice of termination of the proceedings when any of the following events has occurred:
>
> (a) A defendant has not filed an answer within 20 days of the date of service;
>
> (b) A hearing has not been held within 120 days from the date of the filing of the claim and no extension order has been entered by the judicial referee;
>
> (c) An extension order has been entered by the judicial referee but the hearing has not been commenced within six months from the date of the filing of the claim; or
>
> (d) The final hearing has not been concluded within 10 months from the date the claim is filed.
>
> Termination for any of the foregoing reasons terminates the jurisdiction of the panel. Such termination is final and cannot be extended, modified or reinstated by the panel, the judicial referee or by agreement of the parties. A termination for one of the foregoing reasons is automatic, and the clerk's act or failure to act is ministerial only.

[121] 381 So.2d at 233-34. The mediation referee dismissed the first session because of inflammatory statements made by the medical expert on the panel to the claimant, thus indicating prejudice. Physician-petitioner in *Aldana* moved to reset a hearing one month later. Petitioner made this request because of the rigid statutory time restraints in the act which would have forced the respondent to waive her statutory ten day period to challenge panel members—an action which respondent refused to undertake. Unable to extend or shorten the time period in which respondent could challenge for cause, the referee terminated the mediation proceedings.

[122] 381 So.2d at 236.

[123] 335 So.2d 802 (Fla. 1976).

burden case upon the claimant by permitting continuances and extensions of time under section 768.44(3) would transcend those outer limits of constitutional tolerance."[124]

Diversity of Citizenship: Federal or State Jurisdiction

Medical malpractice cases brought before federal courts under diversity of citizenship create an interesting issue with respect to medical malpractice panels. The issue involves the effect on such cases of state laws which require litigants to submit their claims to screening panels before bringing the action into state court.

The issue arises when a plaintiff, who is a resident of one state, wishes to bring suit against a physician who is a resident of another state. The question is whether that plaintiff may proceed directly to the federal court for trial (under diversity of citizenship) or whether he or she must first submit the claim to the forum state's pre-trial screening process.

A case in which such a situation arose was *Soricelli v. Baker*.[125] Plaintiff, a resident of New Jersey, brought suit in the District Court of Pennsylvania against defendant-physician, a Pennsylvania citizen. The alleged tort of malpractice was committed in Pennsylvania. Plaintiff had not complied with the procedures established by the Pennsylvania Arbitration Panel for Health Care[126] before filing in federal district court. By proceeding directly to federal court, plaintiff hoped to circumvent Pennsylvania's pre-trial panel procedures. The district court held for defendant-physician who argued that pre-trial panel procedures should be followed.[127]

The Court of Appeals upheld the District Court's decision on two theories. First, the court rejected appellant's contention that the pre-trial submission requirement was "procedural,"[128] thereby quashing the argument that state procedural law is not binding on federal courts. The court

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[124] 381 So.2d at 238.

[125] 610 F.2d 131 (3d Cir. 1979). *See also* Hines v. Elkhart Gen. Hosp., 465 F. Supp. 421 (N.D. Ind.), *aff'd*, 603 F.2d 646 (7th Cir. 1979); Woods v. Holy Cross Hosp., 591 F.2d 1164 (5th Cir. 1979); Seoane v. Ortho Pharmaceuticals, Inc., 472 F. Supp. 468 (E.D. La. 1979); Davidson v. Sinai Hosp. of Baltimore, Inc., 462 F. Supp. 778 (D. Md. 1978); Marquez v. Hanneman Medical College & Hosp., 435 F. Supp. 972 (E.D. Pa. 1976); Wells v. McCarthy, 432 F. Supp. 688 (E.D. Mo. 1977); Flotemersch v. Bedford County Gen. Hosp., 69 F.R.D. 556 (E.D. Tenn. 1975); Comment, *The Confrontation Between State Compulsory Medical Malpractice Screening Statutes and Federal Diversity Jurisdiction*, 1980 DUKE L.J. 546, 547 n.3 (1980).

[126] The Health Care Services Malpractice Act, 40 P.S. §§ 1301.101 to .1006 (Purdon Cum. Supp. 1979).

[127] 610 F.2d at 133.

[128] *Id.* at 133. The contention that the program was merely "procedural" was based upon an attempt to invoke an exception to Erie Railroad Co. v. Tompkins, 304 U.S. 64 (1938), which held that federal courts must apply state substantive laws to diversity actions.

further held that if a state court has "closed its doors" on a case, the federal court would do the same.[129] Second, the court rejected appellants' argument that "affronting affirmative countervailing federal considerations"[130] were present, such as the delays which would allegedly result if the litigants were required to submit their claims initially to the state screening panels. The court found that neither the method of pretrial arbitration nor the negative results arising from this form of trial management were essential enough to warrant reversal in light of the formula for such solutions set down in *Erie v. Tompkins*.[131]

The dissent in the Pennsylvania District Court strongly opposed the majority's steadfast adherence to the *Erie* doctrine.[132] According to the dissent, the court is obligated to hold itself as an independent federal forum. The dissent weighed the success of the panels in relation to the competing federal and state interests and concluded that the majority's decision served not only to preclude out-of-state litigants from federal court, but also to limit the scope of the federal question that may be posed.[133]

At the time of this writing, the majority's decision to require litigants to submit their claims to state screening panel procedures prior to litigation in the federal courts seems to be indicative of the prevailing consensus in many courts.[134] While protection of state court jurisdiction against encroaching federal court jurisdiction is important, the authors can only

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[129] 610 F.2d at 134. The court stated that

> appellants, as federal plaintiffs seeking medical malpractice damages, may not have rights superior to state citizen plaintiffs, because a fundamental notion underlining *Erie* is that federal courts sitting in diversity merely provide an impartial forum, not a different set of legal rules.

See also Hanna v. Plummer, 380 U.S. 460 (1965). *Hanna* involved a direct conflict between a federal rule and a state procedure. The Court in *Hanna* established that rules of federal procedure (in this case, the Federal Rules of Civil Procedure) are based on the Federal Rules Enabling Act, 28 U.S.C. § 2072 (West Supp. 1981), and have an independent constitutional basis. Thus, federal procedural rules should be applied to matters properly classified as procedural, while state substantive laws should be applied to substantive issues. In *Soricelli,* the court concluded that the controversy surrounding the panels involves substantive issues, and accordingly dismissed appellants' first contention.

[130] 610 F.2d at 135. *See also* Byrd v. Blue Ridge Rural Electric Cooperative, 356 U.S. 525 (1938). This case extends *Erie;* in *Byrd,* the Court held that a state procedural rule need not be followed by the federal courts if a dominant federal interest is present, and visa versa.

[131] 304 U.S. 64; *see also* Edelson v. Soricelli, *supra* note 127.

[132] 610 F.2d at 143.

[133] Comment, *Mandatory State Malpractice Arbitration Boards and the Erie Problem:* Edelson v. Soricelli, 93 HARV. L. REV. 1562, 1572-73 (1980).

[134] In 1980, the Pennsylvania Supreme Court declared the state's panel screening procedures to be unconstitutional. It is significant to note that the dissent in *Soricelli* became one of the major factors leading to this decision. The decision undoubtedly rested upon the great failure rate of the panels—a fact commented on by the *Soricelli* dissent. *See also* Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980).

agree with the dissent in *Soricelli* that relief to out-of-state litigants should be preserved by an independent federal court. Such was not the case in Pennsylvania,[135] nor is it the case in a majority of states where screening panels are still used.[136] This deprivation of the right to go directly to federal court in view of obviously failing programs in the state systems should not bar litigants from an alternative chance for relief in such a desperate situation.

The Right to Trial by Jury

The denial of the right to trial by jury has met with mixed results when asserted by litigants challenging the constitutionality of medical malpractice acts.[137] This may have resulted in part because such challenges must be based on varying state constitutional provisions since the right to trial by jury in civil matters, guaranteed by the Seventh Amendment, has not been made applicable to the states by the Fourteenth Amendment.

Cases challenging the deprivation of the right to trial by jury initially did so on two grounds: (1) the imposition of the mandatory panel hearing procedure is an unconstitutionally burdensome restriction on an action which existed at common law, and (2) the admission into evidence of the panel's findings at a subseqent jury trial, either with or without calling one of the panel members as a witness, creates an onerous condition and unfairly influences the jury in its determination of the facts.[138] A new strategy has emerged, however, which makes use of recently available detailed statistics of panel failure rates.[139] Litigants, armed with these dismal statistics, have been able to persuade courts that the panels' backlog inefficiency has defeated the legislative scheme under which they were enacted, at the expense of the litigants' constitutional rights.[140] Prior to the availability of these statistics, litigants frequently lost.[141] Such losses could be attributed, as mentioned earlier, to various state constitutional guarantees, and in most cases, the procedures of the panels themselves.[142]

The prevailing rationale of the courts in the early decisions in the area of deprivation of rights was based on the theory that the relevant legisla-

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[135] Edelson v. Soricelli, 610 F.2d 131 (3d Cir. 1979).

[136] These states are Florida, Pennsylvania, and New York.

[137] *See, e.g.*, Parker v. Children's Hosp. of Philadelphia, 483 Pa. 106, 394 A.2d 932 (1978); Simon v. St. Elizabeth Medical Center, 3 Ohio 3d 164, 355 N.E.2d 903 (1976).

[138] *See, e.g.*, Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980).

[139] *Id.* at 395-96, 421 A.2d at 195.

[140] *Id.*

[141] *See, e.g.*, Parker v. Children's Hosp. of Philadelphia, 483 Pa. 106, 394 A.2d 932 (1978); Simon v. St. Elizabeth Medical Center, 3 Ohio 3d 164, 355 N.E.2d 903 (1976).

[142] For example, some states' panel members are allowed to testify at subsequent trials. And in some states, panel members may allow panel decisions to be entered as evidence.

tion did not absolutely deny access to the jury, but merely postponed it or supplemented it.[143] As long as the case ultimately reached the jury, the courts were willing to uphold the condition precedent (submission to the panel prior to litigation), although one court viewed it as "reaching the outer limits of constitutional tolerance."[144]

An early Pennsylvania decision, in a line of cases ruling on the constitutionality of the state's malpractice act, upheld screening panel procedures as non-violative of the right to trial by jury.[145] (Emphasis is placed on the chronology of the decision since three years later the same court declared the Pennsylvania act unconstitutional because of a denial of the right to trial by jury. A more detailed discussion will follow in this section.) The Pennsylvania Supreme Court, relying on the constitutional language of that state's constitutional right to trial by jury did not interpret the provision to be "an absolute unfettered right."[146] Indeed, the Court refused to construe this right in such a manner as to exclude all other methods for disposing of disputes.[147] The Pennsylvania court's rationale was that as long as a jury trial is available prior to a final determination of right to the parties, no denial of rights exists.[148]

In Ohio, the trial court in *Simon v. St. Elizabeth Medical Center*[149] decided that the introduction into evidence of the panel's decision was a violation of the right to trial by jury.[150] The court held that the fact that a panel hearing was required before one could go to trial was not a violation since the award of the panel was not the final determination. The court found plaintiff's arguments persuasive. The court agreed that the burden imposed on the losing party was too great, *i.e.*, the party who lost at the panel hearing would have to overcome a heavy burden at trial in order to counterbalance the effect on the trier of fact of the panel decision which has been introduced into evidence. The court viewed this as a "task not easily accomplished in view of the added weight which juries have traditionally accorded the testimony of experts."[151] This heavy burden discouraged parties from proceeding to trial and thus made the right to trial by jury "not a free and unfettered right as was certainly intended by the framers of Article I, Section 5 of the Ohio Constitution."[152]

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[143] *Id.*

[144] Carter v. Sparkman, 335 So.2d 802, 806 (Fla. 1976).

[145] Parker v. Children's Hosp. of Philadelphia, 483 Pa. 106, 394 A.2d 932 (1978).

[146] *Id.* at 118, 394 A.2d at 938.

[147] *Id.*

[148] *Id.*

[149] 3 Ohio 3d 164, 355 N.E.2d 903 (C.P. Montgomery County 1976).

[150] *Id.* at 168, 355 N.E.2d at 908.

[151] *Id.*

[152] *Id.* Art. I, § 5 of the Ohio Constitution provides that the right to trial by jury "shall be inviolate."

With the passage of time, more and more statistical reports have been compiled which have assessed panels' performances.[153] The results so far have been unquestionably dismal. The availability of such studies have prompted courts to reassess prior rulings that favored panel use. One such court re-evaluation took place in Pennsylvania in 1980 by that state's Supreme Court in *Mattos v. Thompson*.[154]

The Pennsylvania Supreme Court, once optimistic that panels could resolve claims, was faced with statistics that proved that 73% of all cases filed with the panels had not been resolved by them.[155] This backlog, according to the Pennsylvania court, defeated the goal of the act which was to provide prompt adjudication of medical malpractice claims. The court determined that such a backlog "impermissibly burdened the right to jury trial under the state constitution."[156] The Pennsylvania Health Care Services Malpractice Act was therefore held unconstitutional.

It is the authors' contention that as other states throughout the nation also compile detailed statistical reports on screening panels' performances, similar failure rates will appear.[157] If such is the case, it is the authors' hope that courts will be guided by the wisdom of the Pennsylvania Supreme Court and put an end to medical malpractice screening panel procedures that impermissibly infringe on litigants' constitutional rights.

Recent Developments

Recently, three states which had upheld the constitutionality of their medical malpractice screening procedures—Florida,[158] Pennsylvania,[159] and New York[160]—have taken a closer look at their systems and have concluded that they do not achieve the purposes for which they were created. In two states, Florida[161] and Pennsylvania,[162] the supreme courts of those states overruled their previous decisions. In addition, New Jersey has published statistics based on a limited experience with mandatory panels.[163]

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[153] For an example of the type of statistics which are kept, *see* Mattos v. Thompson, 491 Pa. 385, 393-95, 421 A.2d 190, 194-95 (1980).

[154] 491 Pa. 385, 421 A.2d 190 (1980).

[155] *Id.* at 396, 421 A.2d at 195.

[156] *Id.*, 421 A.2d at 196.

[157] It is axiomatic that the aforementioned figures fairly represent what can be expected in terms of performance from the screening panels. Hence, it is asserted herein that negative results will continue to be reported until these panels are abolished.

[158] *See* Carter v. Sparkman, 335 So.2d 802 (Fla. 1976).

[159] *See* Parker v. Children's Hosp. of Philadelphia, 483 Pa. 106, 394 A.2d 932 (1978).

[160] *See* Comiskey v. Arlen, 55 A.D.2d 304, 390 N.Y.S.2d 122 (1976).

[161] *See* Aldana v. Holub, 381 So.2d 231 (Fla. 1980).

[162] *See* Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980).

[163] 105 N.J.L.J. 435 (1980).

New York's statute,[164] which establishes mandatory medical malpractice screening procedures, provides for panels consisting of a judge, an attorney, and a doctor.[165] The panel holds informal hearings and, if there is a unanimous decision on the question of liability, that decision may be admitted into evidence in any subsequent trial to be accorded whatever weight the jury may choose to give it.[166] The doctor and attorney panel members may also be called as witnesses but only with reference to the panel's recommendation.[167] The purpose of the panels is to eliminate spurious claims and to provide for out-of-court settlements, thereby reducing the pressure on over-crowded court calendars and reducing the time, effort, and expenses of all parties and the courts.[168]

In *Comiskey v. Arlen,* the constitutionality of subsection 8 of section 148-a of the New York Judiciary Law, dealing with the admissibility of a unanimous panel decision, was challenged on the grounds that it denied access to courts and infringed on the right of trial by jury.[169] Both arguments were rejected and other due process and equal protection arguments were found to be without merit based on an "ends justifies the means" rationale.[170]

In 1978, New York formed the Ad Hoc Committee on Medical Malpractice Panels for the purpose of determining whether or not medical malpractice panels were in fact living up to the purposes for which they were created.[171] The committee examined the amount of court time and money involved in the process and the impact of the panel determinations on any subsequent trials.[172] The period analyzed ran from January 1976 through June 1978.[173] The committee's findings lead them to conclude that mandatory panels should be abolished and replaced with a voluntary system, with the authority to promulgate the rules vested in the Chief Administrator of the Courts.[174] The panels' costs in time and money were found to "[exceed their] benefit to the judiciary, the bar, the medical profession and to society in general"[175] and had not solved the medical malpractice crisis which lead to their creation.[176]

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[164] N.Y. JUD. LAW § 148-a (McKinney Supp. 1979).
[165] *Id.* § 148-a, subd. 2.
[166] *Id.* § 148-a, subd. 4.
[167] *Id.*
[168] *See* GAGLIARDI REPORT, *supra* note 25, at 1.
[169] 55 A.D.2d 304, 390 N.Y.S.2d 122 (App. Div. 1976).
[170] *Id.* at 315, 390 N.Y.S.2d at 130.
[171] *See* GAGLIARDI REPORT, *supra* note 25, at 2.
[172] *Id.*
[173] *Id.* at 140.
[174] *Id.* at 165.
[175] *Id.*
[176] *Id.*

The committee's investigation found that instead of encouraging settlements before trial, the panel procedure discouraged it.[177] Medical malpractice cases were settled at a 68% rate while "other tort" cases were disposed of at a rate of 83.5% and motor vehicle tort cases at 87.5% for the same three-year period.[178]

Furthermore, the number of medical malpractice cases filed had increased from 2% to 4%.[179] Moreover, the cost incurred in maintaining the panels exceeded $400,000.00 per year, excluding judicial salaries.[180] The performance rate of the panels for settling cases during the panel hearing was low (4.3%) because litigants usually wanted to know the panels' recommendation before entering into serious settlement negotiations.[181]

The panels were also found to exacerbate the malpractice crisis in the area of dollar value of settlements.[182] In cases where plaintiffs received a unanimous panel recommendation, they demanded extremely high settlement amounts or proceeded to trial with renewed confidence in their ability to reach a favorable jury verdict.[183] In contrast, the committee found that in those judicial districts where pretrial conferences were held before submission to the panels, there was a settlement rate of 23% and the dollar value of the settlements was substantially less than those settlements reached after the panels made their recommendations.[184]

Significantly, the committee came to identify many constitutional problems associated with the system of mandatory panels, but was most troubled by Seventh Amendment considerations.[185] The committee also questioned whether the panels' hearing process was fair and whether special preference should be given to medical malpractice cases over other tort cases.[186] The committee recommended immediate repeal of the act.[187]

In the Pennsylvania decision of *Parker v. Children's Hospital of Philadelphia*,[188] the issue arose as to whether the panel as a condition

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[177] *Id.* at 163.

[178] *Id.* at 161. There is no indication in the report what the settlement rate was before the institution of the mandatory panel procedure.

[179] *Id.* at 162.

[180] *Id.*

[181] *Id.* at 163-64.

[182] *Id.* at 162-63.

[183] *Id.*

[184] *Id.* at 140-41.

[185] *Id.* at 166.

[186] *Id.* at 167. Medical malpractice actions constituted only 2.5% of the total civil calendar in the first nine months of 1979. *Id.* at 159.

[187] *Id.* at 165.

[188] 483 Pa. 106, 394 A.2d 932 (1978).

precedent was a violation of the right to trial by jury, the same question that was addressed in the New York case of *Comiskey v. Arlen*.[189] In *Parker,* the appellant's brief cited statistics (not given in the court's opinion) which indicated that the panel procedure was not providing for an expeditious disposal of malpractice cases.[190] The Pennsylvania court dismissed the validity of the statistics, claiming that the period of time covered by the data was

> insufficient to establish. . .that the legislative scheme is incapable of achieving its stated purposes. . . . It is an acceptable principle of constitutional law that deference to a co-equal branch of government requires that we accord a reasonable period of time to test the effectiveness of legislation.[191]

Pennsylvania has now had a reasonable period of time. In *Mattos v. Thompson*,[192] the court reversed its earlier decision which had upheld the state's malpractice screening panel statute. In *Mattos,* plaintiff reopened the constitutional challenge to the Pennsylvania Health Care Services Malpractice Act.[193] Two issues—violation of the constitutional guarantee of access to courts and the right to trial by jury—were raised in both the earlier *Parker*[194] case and the *Mattos* case. In *Parker,* the court held that it was as yet premature to determine whether the act violated the Pennsylvania Constitution.[195] However, four years later, the court in *Mattos* reached the conclusion that the delay caused by the panels burdened the right to a jury trial to such an extent that trial by jury became "practically unavailable."[196]

The statistics reviewed by the *Mattos* court covered the period from April 6, 1976 to May 31, 1980.[197] Of the 3,452 malpractice cases filed, only 936 had been resolved, settled, or terminated.[198] The court was appalled by the fact that six of the original forty-eight cases filed in 1976 still had not as yet been resolved.[199] Furthermore, the statistics revealed that 38% of the cases filed in 1977, 65% of those filed in 1978, and 85% of those filed in 1979 were still open.[200] The court declared that such

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[189] 55 A.D.2d 304, 390 N.Y.S.2d 122 (App. Div. 1976).
[190] 483 Pa. at 121, 394 A.2d at 940.
[191] *Id.*
[192] Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980).
[193] *Id.*
[194] 483 Pa. 106, 394 A.2d 932 (1978).
[195] *Id.*
[196] 491 Pa. at 396, 421 A.2d at 195, *quoting Parker,* 483 Pa. at 119, 394 A.2d at 939.
[197] 491 Pa. at 393, 396, 421 A.2d at 194-95.
[198] *Id.*
[199] *Id.*
[200] *Id.*

delays were unconscionable and found section 309 of the act, giving the panels original exclusive jurisdiction, to be unconscionable since the statistics had shown that the "legislative scheme is incapable of achieving its stated purpose" of prompt dispute resolution.[201]

Similarly, in the Florida case of *Aldana v. Holub*[202] which followed the earlier decision of *Carter v. Sparkman*,[203] the court found the statute unconstitutional because "the Act in operation has proven arbitrary and capricious."[204] The decision was necessitated by the fact that, in over 50% of the cases filed, the defendant's statutorily created right to mediation had disappeared because the panel's jurisdiction to hear the case had lapsed through no fault of the parties to the action.[205] Under the statute and the rules of court, it was necessary that a final panel hearing on the merits be scheduled or completed within the ten-month jurisdictional period.[206] This period could not be extended or tolled under any circumstances.[207] Thus, congested court dockets, or administrative or judicial error often caused the jurisdiction of the panels to expire.[208] This situation caused the court to reverse itself and declare the act unconstitutional because

> we have authority to determine that the practical operation and effect of the statute has rendered it unconstitutional. . . . [I]t is based on the unfortunate fact that the medical mediation statute has proven unworkable and inequitable in practical operation.[209]

In May 1980, the New Jersey Supreme Court's Committee on Relations with the Medical Profession issued an interim report detailing the New Jersey experience with Rule 4:21 for the period of January 2, 1979 to October 31, 1979.[210] Emphasizing that the statistics were of little probative value because of the limited number of cases that had been concluded, the committee still found the results encouraging.[211] In certain instances, the statistics paralleled those of New York.

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[201] *Id.*

[202] 381 So.2d 231 (Fla. 1980).

[203] 335 So.2d 802 (Fla. 1976).

[204] 381 So.2d at 235.

[205] *Id.* at 237.

[206] FLA. STAT. ANN. § 768.44(3) (West Cum. Supp. 1979), *quoted at* 381 So.2d at 233, n.2; Florida Rules of Medical Mediation Procedure R.20.190, *quoted at* 381 So.2d at 235, n.6.

[207] Rule 20.190, *supra* note 206.

[208] Of over seventy cases examined by the Court, twenty-six found that jurisdiction terminated under § 768.44(3). Of those twenty-six cases, jurisdiction in fifteen terminated through no fault of either party. Aldana v. Holub, 381 So.2d 231, 237 (Fla. 1980).

[209] 381 So.2d at 237.

[210] 105 N.J.L.J. 425, 435 (1980).

[211] *Id.*

The statistics before the committee concerned cases scheduled for malpractice panel hearings over a ten-month period[212] and reflected the fact that 24% were settled before the commencement of the panel hearing.[213] Of the 112 cases heard, 81% were decided by a unanimous panel decision.[214] Eighty-two percent of the unanimous 112 cases that had completed the panel process had also been disposed of by the courts, with seventy-one cases dismissed, either voluntarily or involuntarily, indicating, according to the committee, a high settlement rate.[215]

The committee discovered that the length of the panel hearings was very short, the average being three-and-one-half hours.[216] Oral testimony tended to prolong the hearing another one-and-three-quarter hours.[217]

In its report, the committee proposed several amendments to the rule to clarify some problems it encountered. It was suggested that the provision for calling the doctor panelist in a subsequent trial be eliminated since the committee was informed that the provision was discouraging doctors from volunteering as panelists.[218] A change in Rule 4:21-5(e) was recommended in order to clarify what should be included in the panel's order. The recommendation stated that the rule should contain "(1) [a] determination whether the claim is based on reasonable medical probability and (2) the specific findings of fact of the panel."[219] However, it was also specified that the order should contain no reference to specific evidence presented to the panel.[220] Since no time limit was indicated in Rule 4:21-6 as to when a request for a rehearing had to be made, the proposed rule amendment provided that the request be made within fifteen days after the order is signed.[221]

Overall, the committee appeared to be encouraged by the results and made no move toward the elimination of the rule. No mention was made in the report of any possible constitutional problems with the rule.[222]

The New Jersey Superior Court continues to view malpractice screening panel procedures as constitutional. In a recent decision, the court held that "the Supreme Court should not be prohibited from resolving procedural problems merely because of a slight effect upon some substantive

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[212] *Id.*
[213] *Id.*
[214] *Id.*
[215] *Id.*
[216] *Id.*
[217] *Id.*
[218] *Id.*
[219] *Id.*
[220] *Id.*
[221] *Id.*
[222] *Id.*

right."[223] It is the authors' opinion that the New Jersey procedure is a blatant violation of constitutional rights; moreover, the authors contend that a close statistical examination of statewide panel performances will reveal a dismal failure rate similar to that which was found in New York and Pennsylvania.

The Superior Court has failed to examine sufficiently the substantive questions concerning the constitutionality of malpractice panels in the following areas:

(1) Due process (denial of the right to cross-examination);
(2) Right to trial by jury;
(3) Equal protection;
(4) Access to courts; and,
(5) Separation of powers.

This article has shown that courts throughout the nation have reached mixed results in deciding the constitutionality of screening panels based upon the above five grounds. The emerging strategy—incorporation of panel statistics into the litigants' arguments—appears, however, to be leading to more consistent results. Sufficient time has passed since the enactment of mandatory screening panels in New Jersey so that the New Jersey courts should be aware, either independently or through evidence offered by litigants, of the panels' success or lack of it. It is the authors' opinion that without such data, the courts will most assuredly uphold the panel procedures in decisions that are reminiscent of those by the Florida Supreme Court in *Carter v. Sparkman*,[224] and by the Pennsylvania Supreme Court in *Parker v. Children's Hospital of Philadelphia*.[225] Both of these supreme courts have since declared their states' panel procedures to be unconstitutional in light of their dismal success rates.

The New Jersey courts have failed to align the protected constitutional rights of litigants with the objectives originally sought by the New Jersey Supreme Court, especially in view of what is now known about the panels' overall performance. The authors contend that if the New Jersey courts were to examine available statistics on the performance of New Jersey's panels (which the authors hypothesize would be similar to those in New York and Pennsylvania), they would change their opinion of panel procedures from that of a "slight effect upon substantive rights"[226] to one which would more accurately describe the panel procedures as an intolerable burden on litigants which "would transcend these outer outer limits of constitutional tolerance."[227]

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[223] Suchit v. Baxt, 176 N.J. Super. 407, 427, 423 A.2d 670, 680 (Law Div. 1980).
[224] 338 So.2d 802 (Fla. 1976).
[225] 483 Pa. 106, 394 A.2d 932 (1978).
[226] 176 N.J. Super. 407, 423 A.2d 670 (Law Div. 1980).
[227] 381 So.2d at 238.

In light of the New York, Florida, and Pennsylvania experiences, states with medical mediation panels should maintain detailed statistics on those panels. Since most states have been reluctant to declare the panels unconstitutional in the abstract, statistics that show them to be ineffectual may be the only weapon available for their destruction.

Conclusion

In light of the constitutional issues raised in this article, the high incidence of decisions going against plaintiffs, and the failure of the legislation in several states to fulfill its original intent, the authors conclude that the mandatory element of the panels should be eliminated. It is the authors' feeling that such a requirement is fundamentally unfair and only worsens the malpractice situation. The courts, by upholing the constitutionality of panel legislation, have gone out of their way to find a rational basis upon which to justify the statutes' existence. No definitive data has been presented in any of the cases to substantiate the fact that a medical malpractice "crisis" existed in any state at the time the statutes were enacted. Neither the courts nor the legislatures have shown that screening panels are the best or only solution to the problem of high malpractice insurance premiums.

As more statistics are collected on the ability of screening panels to meet the purposes for which they were established, the authors feel that it will become overwhelmingly evident that the legislatures have created a system that neither aids the general public nor solves the perceived problems. Other methods must be developed which do not impinge on constitutional rights.

The previously discussed problems can be obviated by eliminating the mandatory submission element, but allowing the panels to remain in operation as mediation boards for those who feel they need to avail themselves of such a procedure. A vigorously conducted pre-trial conference can accomplish many of the purposes for which the panels were originally established. This simpler procedure would insure constitutional protection for all litigants and the availability of direct remedies from the courts.