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HEALTH CLAIMS ARBITRATION IN MARYLAND: THE EXPERIMENT HAS FAILED

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The authors note that Maryland's system for health claims arbitration has failed to reduce the number of malpractice suits, the size of damages awards, or the delay in resolving these claims. After reviewing the current system, its strengths and weaknesses, and various proposals to remedy its problems by amending the current legislation, the authors advance their own suggestions for amending Maryland's health claims arbitration legislation.

I. INTRODUCTION

With only the most laudable objectives in mind, the Maryland General Assembly passed the Maryland Health Claims Arbitration Act in 1976.[1] The legislators adopted the Act to remedy a perceived crisis in the way that malpractice cases were being handled at common law. The major symptoms of this crisis were an unparalleled rise in the number of suits against health care providers and skyrocketing medical malpractice verdicts. As a cure, the legislature required most malpractice suits be arbitrated before being filed in the state's trial courts.

Health claims arbitration has failed to live up to its promise. It has neither reduced the number of malpractice suits nor reduced the size of awards. Rather, recent statistics reveal not only a rise in the number of malpractice claims filed, but, overall, arbitration panels have been more generous, in awarding damages, than their jury counterparts. Also, by requiring arbitration before litigation, the arbitration Act has extended the delay all parties must endure between medical injury and final adjudication. To some, these developments suggest that health claims arbitration has exacerbated the very problems it was designed to solve, while others look upon arbitration as being totally ineffective.

To understand why the arbitration system has failed, the reasons for its enactment must be understood. Hence, this article opens with an exploration of the unique concerns and interests that distinguish medical malpractice from other areas of the law. Mindful of these concerns, the so-called "medical malpractice crisis" of the early 1970's is examined in terms of its causes. The next section includes an explanation of the arbi-

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1. Health Claims Arbitration Act, ch. 235, 1976 Md. Laws 495.

tration statute and an analysis of where and why it has failed to meet its objectives. The bulk of the analysis is devoted to an appraisal of the many solutions that have been proposed to solve the problems with the current approach to arbitration. The goal of this analysis is to demonstrate that a health claims arbitration system can work if it is engineered with an understanding of its limitations. This understanding of the limitations of the arbitration system also serves as a framework for a comprehensive amendment to the Act.

II. MEDICAL MALPRACTICE: IS IT REALLY SO DIFFERENT?

Like so many areas of the law, medical malpractice litigation has become quite specialized. To those who do not practice it, and to attorneys who only dabble in it, the law of medical malpractice is perceived as arcane, fraught with needless complexity and with unjustifiable expenses. These complaints, however, are merely an acknowledgment of the problems and interests unique to malpractice cases. It is these problems and interests that cause much of the expense and delay experienced by parties involved in a malpractice suit.

A. Complexity

In truth, the substance of medical negligence law is no more complicated than that of general negligence law. To make a case against a health care provider, a patient who has been wronged need only prove duty, breach of duty, injury, and a causal nexus between the breach and the injury.[2] Unlike ordinary negligence actions, however, medical malpractice involves the conduct of a professional. As a professional, the defendant physician can be held liable only if he fails to conform his conduct to the accepted professional standard of care.[3] In other words, "a physician is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances."[4] On its face, this is a fairly simple proposition. Certainly, it is no more complicated than the cryptic "risk/utility" test applied in products liability suits.[5]

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2. Suburban Hosp. Ass'n v. Mewhinney, 230 Md. 480, 484-85, 187 A.2d 671, 673 (1963); Hahn v. Suburban Hosp. Ass'n, 54 Md. App. 685, 695, 461 A.2d 7, 13 (1983).
3. *See generally* Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 199, 202, 349 A.2d 245, 253, 254 (1975) (articulating the rules for physicians and hospitals). The application of a professional standard to physicians is a time worn proposition in Maryland. *See* Dashiell v. Griffith, 84 Md. 363, 380-81, 35 A. 1094, 1096 (1896); State *ex rel.* Janney v. Housekeeper, 70 Md. 162, 172, 16 A. 382, 384 (1889).
4. Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 200, 349 A.2d 245, 253 (1975).
5. This test is used in cases involving design defects. Eaton Corp. v. Wright, 281 Md. 80, 375 A.2d 1122 (1977); Jensen v. American Motors Corp., 50 Md. App. 226, 437

What complicates medical malpractice cases is the subject matter.[6] Medicine is a complicated science. Arbitration panels and lay juries are often called upon to answer questions such as how long a patient has had adenocarcinoma of the left breast; whether a patient has a severe characterological disorder or a biological depression; and whether injuries are attributable to the interaction of Takayashu's disease with hypertension.

It is not difficult to understand why lay jurors might have a problem resolving these issues. In recognition of this difficulty, the Maryland judiciary has steadfastly required that expert testimony be used to explain the standard of medical competence to which the defendant physician should be held, and to show any deviation from that standard.[7] In contrast, when both of these issues are so clear that the lay person can understand the case without assistance, expert testimony is not required.[8]

Establishing the standard of care is not always simple because it varies according to "advances in the profession, availability of facilities, specialization or general practice, proximity of specialists and special facilities."[9] As a result, the experts for both sides must familiarize themselves with these variables because what would be negligent for a physician practicing in one locality might not be negligent for a different physician in a different locality.

Once the appropriate standard has been established, the plaintiff must show that it has not been met.[10] The very nature of the medical profession makes this a difficult task. Medicine is a practice that requires

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A.2d 242 (1981). *See generally* Phipps v. General Motors Corp., 278 Md. 337, 363 A.2d 955 (1976) (landmark case adopting strict liability in Maryland).

6. The framers of the Health Claims Arbitration Act cited these complexities as reasons for modifying the common law approach to malpractice cases. *See* MARYLAND STATE BAR ASS'N, REPORT OF THE SPECIAL COMMITTEE TO CONSIDER PROBLEMS RELATED TO MEDICAL MALPRACTICE IN MARYLAND 2 (1976) [hereinafter cited as SPECIAL COMMITTEE].
7. *See, e.g.*, Johns Hopkins Hosp. v. Genda, 255 Md. 616, 622-23, 258 A.2d 595, 599 (1969); Fink v. Steele, 166 Md. 354, 361, 171 A. 49, 52 (1934); Dunham v. Elder, 18 Md. App. 360, 363-64, 306 A.2d 568, 570-71 (1973). Expert testimony also prevents jurors from speculating about matters which they do not understand. 3 C. KRAMER, MEDICAL MALPRACTICE § 29.01, at 29 (1983).
8. The two recognized exceptions are: (1) informed consent, Sard v. Hardy, 281 Md. 432, 379 A.2d 1014 (1977); and (2) instances when the deviation from the standard of care is so clear that a layman could understand it was negligent, Thomas v. Corso, 265 Md. 84, 288 A.2d 379 (1972) (doctor negligently failed to attend to a patient who needed emergency treatment); Suburban Hosp. Ass'n v. Hadary, 22 Md. App. 186, 322 A.2d 258 (1974) (use of non-sterile needle); Holloway v. Hauver, 22 Md. App. 303, 322 A.2d 890 (patient swabbed with alcohol shortly before a spark-causing machine ignited the alcohol), *cert. denied*, 272 Md. 742 (1974).
9. Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 200-01, 349 A.2d 245, 253 (1975). There are also differences among specialists who subscribe to different schools of thought. PROSSER AND KEETON ON THE LAW OF TORTS 187 (W. Keeton 5th ed. 1984) [hereinafter cited as PROSSER AND KEETON].
10. In meeting this burden, the plaintiff must overcome the presumption of due care that operates in favor of the physician. *See* Riffey v. Tonder, 36 Md. App. 633, 647-51, 375 A.2d 1138, 1146-47 (1977). Additionally, liability can never be predicated

constant vigilance and technical skill, coupled with tremendous intuition and judgment. It is not practiced by the infallible Marcus Welby or by an arithmetically precise computer. Rather, it is practiced by ordinary, dedicated, intelligent, and well-meaning human beings who sometimes err.[11] The chore of reconstructing the judgment call or mistake that injured the patient is seldom easy.

Errors in medical judgment are as difficult to identify as they are to prove. To say that the area of medical judgment is a gray area is to slight it by understatement. Start with the proposition that the cases involve a human body, an organism so complicated that modern medicine has only begun scratching the surface of many of its intricacies. Then continue with the idea that, while the tools for evaluating defects in the human body have become sophisticated and widely available, they are not infallible. Moreover, these tools are only as reliable as the human being who translates the data produced by them into a diagnosis.

Actually proving medical errors in court is an equally complicated proposition. Because the plaintiff has the burden of going forward, he must show exactly how the errant physician deviated from the standard of care.[12] Thus, the trial of a malpractice case usually involves recreating the symptoms, the tests, and the recommended courses of treatment for a particular patient. This is usually accomplished through the use of expert testimony. The plaintiff's expert must testify that, under the circumstances, a competent physician would have pursued another course of treatment.

It is this question of circumstances that often becomes the focal point of the heated malpractice battles. Understandably, the plaintiff will attempt to recreate, from a plaintiff's perspective, the circumstances that confronted the doctor. His expert testimony will explain that, under these circumstances, the health care provider could have done better. The defendant physician, in contrast, will attempt to portray the plain-

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solely upon a bad result. Baulsir v. Sugar, 266 Md. 390, 395, 293 A.2d 253, 255 (1972); Lane v. Calvert, 215 Md. 457, 462-63, 138 A.2d 902, 905 (1958).

11. The infrequency of these errors is borne out when it is noted that of all health care providers who are sued for malpractice, only one percent have been sued more than twice before. REPORT OF GOVERNOR'S COMMISSION ON HEALTH CARE PROVIDERS' PROFESSIONAL LIABILITY INSURANCE app. EE, FF (1984) [hereinafter cited as LIEBMANN REPORT]. It should be noted, however, that certain high-risk specialists are sued considerably more frequently. *Id.* at 7.

12. *See* Stevens v. Union Memorial Hosp., 47 Md. App. 627, 424 A.2d 1118 (1981) (insufficient evidence introduced to show negligence because it was possible that other persons present in the operating room might have caused the injury); Hans v. Franklin Square Hosp., 29 Md. App. 329, 338, 347 A.2d 905, 911 (1975) (man who emerged from a hemorrhoidectomy with a clawed hand failed to reconstruct the physician's negligent act because "[t]he necessary antiseptic exclusiveness of the operating room thwarted appellant's every attempt to find the cause of his injury"); *see also* State *ex rel.* Baltimore Eye, Ear & Throat Hosp., 177 Md. 517, 527, 10 A.2d 612, 617 (1940) (there "must be something more than a showing that the evidence might be consistent with the plaintiffs' theory" even though the true plaintiff, the only eyewitness for the appellants, died during surgery).

tiff's case as an unfair attempt to second guess a legitimate medical decision, a medical decision that was made under real life conditions, without the luxury of a dispassionate, leisurely armchair review of all of the available medical information. In other words, the defendant's position will be that he acted as reasonably as he could have under the circumstances.[13]

Lastly, the plaintiff must show that the physician's negligence proximately caused the patient's injuries.[14] This issue also implicates many of the complexities of modern medicine because the patient's condition may be attributable to nothing more than a gap in medical technology that would have yielded a bad result even if the doctor had acted competently.[15] Also, the defendant physician may raise the issue of contributory negligence by arguing that the plaintiff is at least partially responsible for his injury.[16] Because these issues are often no less complex than those of duty and breach of duty, proving causation frequently requires expert testimony.[17]

B. Expenses

As the previous section illustrates, the factual complexities and burdens of proof make expert testimony a necessity in most malpractice cases. Additionally, counsel for both sides generally consult experts throughout the trial preparation period to assist them in understanding the medical issues. This makes preparing and litigating medical malprac-

13. There are a number of legal doctrines that attempt to recognize these real world conditions. Most importantly, the law does not treat a physician as a warrantor of the treatment he prescribes. PROSSER AND KEETON, *supra* note 9, at 186. Rather, the law predicates liability on the health care provider's failure to possess the appropriate level of skill and training. *See supra* notes 3-4 and accompanying text. Thus, the mere fact of an unsuccessful result is not evidence of negligence. *See supra* note 10 and accompanying text. Moreover, in recent years, Maryland's highest court has attempted to adjust the standard of care to account for the variables among practitioners of given specialties and the different facilities available to different doctors. *See generally supra* text accompanying note 9 (different factors considered).
14. Mehlman v. Powell, 281 Md. 269, 378 A.2d 1121 (1977); State *ex rel.* Baltimore Eye, Ear & Throat Hosp., 177 Md. 517, 10 A.2d 612 (1940).
15. Suburban Hosp. Ass'n v. Mewhinney, 230 Md. 480, 485-86, 187 A.2d 671, 673 (1963) (the injury may be "due only to the fact, unfortunate as it may be, that even in this day of modern medicine, many operations by qualified surgeons do not correct the condition treated due to the fault of nothing more than the nature of the injury"); *see also* D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE ¶ 19.02 (1983) (examining the "calculated risk" built into every medical treatment).
16. Moodie v. Santoni, 292 Md. 582, 441 A.2d 323 (1982); McClees v. Cohen, 158 Md. 60, 148 A. 124 (1930).
17. 3 C. KRAMER, *supra* note 7, ¶ 29.01(2); 5A PERSONAL INJURY ACTION, DEFENSES, DAMAGES § 1.01(1)(b)(i) (L. Frumer & M. Friedman ed. 1983) [hereinafter cited as PERSONAL INJURY]. Indeed, proving causation may require expert testimony when it would not have been necessary to use such testimony to prove the standard of care and its breach. *See* Sard v. Hardy, 281 Md. 432, 448, 379 A.2d 1014, 1024 (1977); *see also supra* note 8 (cases that have articulated the exception to the expert testimony requirement).

tice cases an expensive proposition. Experts often charge from $100 to $300 per hour; it is not unusual in a hotly contested and complicated malpractice case for each party to spend over $10,000 in experts' fees.

In addition to expert witness fees, the magnitude and complexity of malpractice litigation mean that countless hours of attorney time are invested in each case. Although plaintiffs' attorneys ordinarily hope to receive compensation for this time by taking a contingency fee, defendants and their insurers usually compensate counsel on an hourly basis.[18] It is not unusual for legal defense-related fees to exceed 22% of the total disbursements of a malpractice insurer.[19]

C. *The Stakes*

The competing interests involved make medical malpractice suits worth pursuing and defending. The health care provider has both personal and financial interests at stake. He stands before the trier of fact charged with having injured one of his patients. This alone can be psychologically wearing upon a physician. Also, he faces a verdict that may tarnish his professional reputation, and, in a case where the allegations of malpractice are serious enough, there is always the possibility that the jury's verdict will exceed the limits of the doctor's malpractice policy. Thus, not only does the defendant face a potential loss of standing in the professional community, but he faces the prospect of incurring a substantial personal financial loss as well.

Second, the patient has been victimized. Medical injuries caused by negligence can be devastating. The file drawers of attorneys who litigate medical malpractice cases are filled with countless tragedies. Surgical accidents, complications of childbirth, and diagnostic inattention can lead to mutilation, paralysis, scarring, mental dysfunctions, and death. Understandably, when negligence is found to have caused one of these tragedies, arbitration panels and juries are not reluctant to award substantial sums of money to the victims.[20] Patients have another interest: the need for swift access to justice. Faced with medical bills and crippling disabilities, patients and their creditors cannot wait several years for compensation. Delayed justice swiftly becomes denied justice.

The interests of attorneys on both sides cannot be ignored. As do all attorneys, they hope to receive compensation for the large amount of time that must be committed to preparing and trying a malpractice case. While some may argue that it is unethical to consider this interest, it is

18. The defendant's interest in containing the cost of defense, namely counsel fees, was recognized in the committee report that gave rise to the Maryland statute. MEDICAL MALPRACTICE INSURANCE STUDY COMMITTEE, REPORT TO THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF 1976 11 (1976) [hereinafter cited as 1976 REPORT].

19. LIEBMANN REPORT, *supra* note 11, at 15.

20. 2 MARYLAND HEALTH CLAIMS ARBITRATION DECISIONS AND MATERIALS (1984) (see "Index by Recovery Amount" which appears after the tab marked "Index") [hereinafter cited as DECISIONS & MATERIALS].

not unethical for an attorney to take a case because he anticipates compensation. Quite the opposite is true: only a foolish lawyer accepts a case without worrying about how he will be paid. Under the contingency fee arrangements frequently negotiated between plaintiff's counsel and client, the attorney hopes to receive a fee that constitutes a percentage of a verdict that could exceed a million dollars.[21] This incentive makes it well worth the cost of bringing malpractice suits. Defense attorneys, by contrast, are compensated on an hourly basis for the time they invest in a case. The cost of defense, therefore, is an interest that the defendant, and more importantly the defendant's insurer, cannot ignore.

Last, there are the concerns of the doctor's insurance carrier. The carrier's interests are usually consonant with the insured's interests, but may sometimes conflict. First, there is always the possibility that the verdict will exceed the policy's limit. Second, in a questionable case of negligence, the insurer may opt to settle a case rather than risk the high cost of defending a protracted suit.[22] The physician, in contrast, may want his conduct vindicated in a public trial. Additionally, some doctors are concerned that a settlement will be used by the carrier to justify a future rate increase.[23]

III. THE ADVENT OF HEALTH CLAIMS ARBITRATION

Maryland has had mandatory arbitration of medical malpractice claims since 1976.[24] The policy and history behind the General Assembly's decision to adopt this arbitration system are well documented.[25] Primarily, arbitration was enacted to halt what was viewed at the time as

21. 1976 REPORT, *supra* note 18, at 11; U.S. DEP'T OF HEALTH, EDUC. & WELFARE, PUB. NO. 73-88, MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 32-33 (1973) [hereinafter cited as HEW]. In recognition of this incentive, some jurisdictions have attempted to regulate contingency fees. *See generally* Annot., 12 A.L.R. 4th 23 (1983) (discussing authorities on the subject).

22. *See supra* text accompanying notes 18-19. It should be noted, however, that an insurance company owes a duty to consider the insured's interest before settling a case. D. LOUISELL & H. WILLIAMS, *supra* note 15, ¶20.06.

23. Comments of the Medical Practice Action Committee 3-4 (1976) (available in Maryland Legislative Reference File HB986); Letter from Marshall A. Diamond, M.D., to Senator Larry Wiser (February 23, 1976) (available in Maryland Legislative Reference File HB986C).

24. It was not until 1978 that the volume of cases began to rise. This initial delay was attributed to a constitutional challenge to the Health Claims Arbitration Act. When the Court of Appeals of Maryland upheld the constitutionality of the Act, Attorney Gen. v. Johnson, 282 Md. 274, 385 A.2d 57, *appeal dismissed*, 439 U.S. 805 (1978), the volume of claims filed increased considerably. *See* LIEBMANN REPORT, *supra* note 11, at 14-15, app. F.

25. Some of this policy is alluded to in Attorney Gen. v. Johnson, 282 Md. 274, 280-81, 385 A.2d 57, 61, *appeal dismissed*, 439 U.S. 805 (1978). Also, the Legislative Reference Service of the Maryland General Assembly has compiled files which contain the written testimony of those who commented upon each of the proposed bills. The Service is located in the basement of the Legislative Resources Building, Annapolis, Maryland.

a malpractice "crisis."[26] This crisis began in the early 1970's with a dramatic increase in the number of malpractice suits being filed and an alarming rise in the dollar amounts of malpractice verdicts.[27] The combined operation of these factors had a significant effect on the health care practitioners and the companies that insured them.

The causes of this upsurge in litigation were in many respects as complicated as the social problems that existed at the time. Among the contributing factors, for example, was the erosion of the traditional doctor-patient bond.[28] Rather than consulting the trusted family physician, patients were turning increasingly to impersonal medical centers. Instead of a patient seeing a general practitioner for all ills, patients were consulting specialists and consultants in increasing numbers.[29] These developments combined to erode the bond of trust and friendship that had existed between doctor and patient. As a result, apprehension about suing the family doctor disappeared and the reverence jurors once possessed for physicians vanished.[30] Finally, it appeared that society as a whole was becoming more litigious.[31] The rush to sue doctors was and is, in part, an outgrowth of this trend.

Certain changes in the law spurred this rush to the courts by making it easier to prove malpractice.[32] For example, in Maryland there has been an abandonment of the strict locality rule.[33] Before this change took place, a patient could only use the testimony of an expert drawn

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26. 1976 REPORT, *supra* note 16; Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489 (1977); Ursic, *Maryland Health Claims Arbitration System*, 12 U. BALT. L.F. 14 (1982); *see also* McGuirk & Rafferty, *Medical Malpractice and the Maryland Legislature*, 6 U. MD. L.F. 9-10 (1976) (the General Assembly acted in a "crisis atmosphere").

27. Abraham, *supra* note 26, at 490.

28. Mechanic, *Some Social Aspects of the Medical Malpractice Dilemma*, 1975 DUKE L.J. 1179, 1183; Comment, *Recent Medical Malpractice Legislation — A First Checkup*, 50 TUL. L. REV. 655, 657 (1976).

29. Quinn, *The Health Care Malpractice Claims Statute: Maryland's Response to the Medical Malpractice Crisis*, 10 U. BALT. L. REV. 74, 76 (1980); Note, *Medical Malpractice Arbitration: A Patient's Perspective*, 61 WASH. U.L.Q. 123, 127-28 (1983). According to the LIEBMANN REPORT, *supra* note 11, 49% of the claimants who filed arbitration claims reported no prior patient relationship between themselves and the defendant physician. *Id.* at app. M; Comment, *supra* note 28, at 657-58.

30. 3 C. KRAMER, *supra* note 7, at viii.

31. *See generally* J. LIEBERMAN, THE LITIGIOUS SOCIETY (1981) (examining the increasing propensity to resort to litigation and its effect on society in general).

32. Many of these developments are reviewed in HEW, *supra* note 21, at 27-31, and Abraham, *supra* note 26, at 495-512.

33. Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 199-201, 349 A.2d 245, 252-53 (1975) (subject of expert's testimony); Raitt v. Johns Hopkins Hosp., 274 Md. 489, 336 A.2d 90 (1975) (location from which the expert must be drawn). For a discussion of the competing policies behind the controversial rule, compare Ellin, *The Laws of Medical Malpractice in Maryland*, 3 U. BALT. L. REV. 207 (1974) (anti-locality rule) with King & Coe, *The Wisdom of the Strict Locality Rule*, 3 U. BALT. L. REV. 221 (1974) (pro locality rule).

from the same locality as the defendant physician.[34] Understandably, in close-knit medical communities, physicians were often reluctant to testify against their colleagues.[35] As a result, many patients' claims were lost for want of expert testimony.[36]

After the abrogation of the strict locality rule, any expert could be called to testify if he was familiar with the standard of care in the defendant physician's medical neighborhood. This neighborhood is deemed to consist of the facilities available to most of the competent physicians in the general vicinity.[37] The result of the abrogation of the strict locality rule was that the state's courts were thrown open to out-of-state experts who had no ties to local physicians. And, experts who make a living by testifying in malpractice cases could be imported by plaintiffs to pierce any local conspiracy of silence that once might have existed.

These social and legal developments, along with the resulting rise in the number of malpractice suits, had identifiable negative effects on the practice of medicine and malpractice insurers. Physicians began to practice defensive medicine by prescribing unnecessary batteries of tests to protect themselves against a charge that they somehow missed an obscure illness.[38] Also, the more apprehensive members of the profession grew reluctant either to undertake high risk operations or to specialize in high risk areas of medicine.[39]

The medical malpractice insurance carriers also reacted to the increased cost of defending this avalanche of malpractice suits. Initially, they responded by implementing dramatic increases in malpractice insurance premium rates. These increases were so expensive that the members of the medical community who had to pay the premiums gained the sympathy of the media and the public at large.[40] When rate increases did not solve the problem, the insurance carriers began to withdraw their medical malpractice coverage from the state.[41]

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34. State *ex rel.* Soloman v. Fishell, 228 Md. 189, 179 A.2d 349 (1962); Dunham v. Elder, 18 Md. App. 360, 306 A.2d 568 (1973).
35. This has been referred to as a "conspiracy of silence." Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 194, 349 A.2d 245, 249 (1975) (citing Note, 40 FORDHAM L. REV. 435, 438 (1971)).
36. *See* Raitt v. Johns Hopkins Hosp., 22 Md. App. 196, 322 A.2d 548 (1974), *rev'd*, 274 Md. 489, 336 A.2d 90 (1975); Dunham v. Elder, 18 Md. App. 360, 367, 306 A.2d 568, 572 (1973).
37. Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 200, 349 A.2d 245, 253 (1975).
38. HEW, *supra* note 21, at 14, app. at 38; Quinn, *supra* note 29, at 75. A recent study by the American Medical Association estimated that $5.1 billion has been spent by doctors on defensive medicine. *See* Middleton, *The Medical Malpractice War*, NAT'L L. J. 1 (Aug. 27, 1984).
39. *See supra* note 38. The problem with light risk specialties is discussed in LIEBMANN REPORT, *supra* note 11, at 7-8.
40. *See* Heintz, *Arbitration of Medical Malpractice Claims: Is it Cost Effective*, 36 MD. L. REV. 533, 533 (1977); Quinn, *supra* note 29, at 75.
41. Quinn, *supra* note 29, at 77. For a discussion of the reasons for this withdrawal, see McGuirk & Rafferty, *supra* note 26, at 10-11. *See also* Saint Paul Fire & Marine Ins.

Faced with the prospect of having largely uninsured medical practitioners, the Maryland General Assembly acted swiftly. First, the Medical Mutual Liability Insurance Company, a physician-owned, state-sponsored insurance carrier, was set up to cope with the loss of the private sector insurance carriers.[42] Second, the health claims arbitration network was fashioned in an effort to attack the root causes of the crisis that had driven the insurers out of the state. This arbitration system has remained relatively unchanged since its inception.[43]

IV. THE PROCEDURES OF ARBITRATION

Procedurally, the operation of the health claims arbitration system is not difficult to understand. The Act requires that "[a]ll claims, suits, and actions, including cross-claims, [and] third-party claims . . . by a person against a health care provider for medical injury allegedly suffered by the person in which damages of more than $5,000 are sought are subject to and shall be governed by the provisions" of the Health Claims Arbitration Act.[44]

In practice, this means that all traditional medical malpractice suits against health care providers "may not be brought or pursued in any court of this state except in accordance with" the Arbitration Act.[45] The cases are heard by a three-member panel consisting of an attorney, a health care provider, and a member of the general public.[46] The attorney, who always serves as the chairperson,[47] is regarded as the guardian of the rule of law; the physician is believed to supply the expertise required to understand the medical complexities; and the layperson is to supply conscience and commonsense, in contrast to his professional counterparts.[48] A number of complicated problems have arisen out of this deceptively simple system.

A. Jurisdiction

Because a plaintiff is required to seek his initial remedy through

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Co. v. Insurance Comm'r, 275 Md. 130, 339 A.2d 291 (1975) (concerning withdrawal of the dominant carrier).

42. MD. ANN. CODE art. 48A, §§ 548-556 (1979).
43. There are, however, a number of regulations and informal rulings that have been issued by the Office of the Director of Health Claims Arbitration. These regulations are comprehensively reproduced in DECISIONS & MATERIALS, *supra* note 20.
44. MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-02(a) (1984). For a discussion of the Act, see McGuirk & Rafferty, *supra* note 26, at 10.
45. MD. CTS. & JUD. PROC. § 3-2A-02 (1984). The sole statutory exemption from arbitration is for actions "in which damages of $5,000 or less are sought." *Id.*
46. MD. CTS. & JUD. PROC. § 3-2A-03(c) (1984). The lay panel member must be selected from the "general public who are neither attorneys, health care providers, or agents or employees of an insurance company or society." *Id.* The parties may, within the time for returning their lists to the Director, agree in writing to have a single arbitrator replace the panel. *Id.* § 3-2A-04(e).
47. *Id.* § 3-2A-05(c).
48. Abraham, *supra* note 26, at 514.

arbitration, a circuit court cannot hear a malpractice claim until it has been "submitted" to arbitration.[49] Thus, before a case can be filed, the patient's attorney must decide whether his client's cause of action is arbitrable. Because not all claims are subject to arbitration, filing in the wrong forum can lead to a dismissal of the suit,[50] often after limitations have run.

It is undisputed that the stereotypical negligence-based malpractice claim falls squarely within the ambit of the Act. But these claims only encompass some of the potential torts that a health care provider may have committed.[51] The Act does not limit itself to these actions, but embraces any "injury arising or resulting from the rendering or failure to render health care."[52] Thus, companion claims pleaded under the liberal joinder rules are also subject to arbitration.

A more difficult question arises when the plaintiff has not based his case against a health care provider on a traditional malpractice theory. Instead, he may have chosen to allege only ordinary, nonmedical negligence,[53] breach of warranty,[54] or various intentional torts.[55] In a series of decisions, Maryland's appellate courts have begun the task of sorting out the arbitrability of these nonmalpractice, medically-based claims.[56]

The one hard and fast rule emerging from these cases is that the inclusion of a negligence count in a complaint will render the entire case subject to arbitration.[57] The sole exception to this rule recognized thus far arises when the claim against a health care provider is "for damages arising from a professional's failure to exercise due care in such non-professional situations such as premises liability, slander, assault, etc."[58] The mere fact that the defendant is a health care provider and the plaintiff is a patient, absent a breach of the professional standard of care,[59] will not subject the plaintiff's claim to arbitration.

Certain intentional torts and contract claims of a "professional nature" are also covered by the Act. Although the courts have yet to articulate a basis for distinguishing arbitrable intentional torts from their non-

49. Bailey v. Woel, 302 Md. 38, 485 A.2d 265 (1984). The failure to arbitrate does not mean that the circuit court lacks jurisdiction; rather, it indicates that a condition precedent has not been fulfilled. *See* Oxtoby v. McGowan, 294 Md. 83, 91, 447 A.2d 860, 864-65 (1982).
50. Schwartz v. Lilly, 53 Md. App. 318, 324, 452 A.2d 1302, 1305 (1982).
51. *See supra* note 2 and accompanying text.
52. MD. CTS. & JUD. PROC. § 3-2A-01(f) (1984).
53. *See* Cannon v. McKen, 296 Md. 27, 459 A.2d 196 (1983).
54. *See* Brown v. Rabbitt, 300 Md. 171, 476 A.2d 1167 (1984).
55. *See* Nichols v. Wilson, 296 Md. 154, 460 A.2d 57 (1983).
56. *See infra* notes 57-62. Additionally, the courts have interpreted the effective date of the mandatory arbitration requirement. *See* Oxtoby v. McGowan, 294 Md. 83, 447 A.2d 860 (1982); Dennis v. Blanchfield, 48 Md. App. 325, 428 A.2d 80 (1981).
57. Nichols v. Wilson, 296 Md. 154, 158-59, 460 A.2d 57, 60 (1983); Cannon v. McKen, 296 Md. 27, 38 n.4, 459 A.2d 196, 202 n.4 (1983).
58. Cannon v. McKen, 296 Md. 27, 36-37, 459 A.2d 196, 202 (1983).
59. *Id.*

arbitrable counterparts, Maryland's highest court has stated that assault and battery and intentional infliction of emotional distress are not arbitrable because they are premised upon an "intentional, malicious, wanton and reckless act."[60] In contrast, a suit based solely upon a physician's breach of an express contractural warranty can be arbitrable if "the claim is based on the rendering or failure to render health care."[61] For example, when the warranty is the type of promise that "[o]nly a physician in his professional capacity could make," the claim must be submitted to arbitration.[62]

B. Third Party Practice

Just as the Act sweeps companion claims within its reach, it uses the rules pertaining to joinder of parties to accomplish a similar result. Under the Act, "[a]ll . . . third party claims . . . are subject to and shall be governed by the arbitration statute."[63] Thus, a health care provider cannot be joined under a malpractice theory as a third party in a nonmalpractice case in the circuit court.[64] Rather, a separate proceeding must be commenced with the health claims arbitration office.

It is not clear whether this language sweeps third party claims against nonhealth care providers within the jurisdiction of the health claims network. A recent court of special appeals decision suggests that nonhealth care providers, such as drug manufacturers, are not a proper party in a health claims proceeding.[65] There is, however, some precedent to the contrary, allowing these third party complaints to be litigated before a health claims panel.[66]

Even if a nonhealth care provider is not a proper party in health claims proceedings, the court of appeals has recognized that a direct claim against a nonhealth care provider based on the derivative liability of a health care provider must be arbitrated.[67] In *Group Health Associa-*

60. Nichols v. Wilson, 296 Md. 154, 161, 460 A.2d 57, 61 (1983). The court, however, limited the potential reach of its decision. In a footnote, it stated: "[w]e do not mean hereby to indicate that all intentional torts of a professional nature are not covered by the Act as there may well be many such acts that would be so covered." *Id.* at 161 n.5, 460 A.2d at 61 n.5. *See generally* PERSONAL INJURY, *supra* note 17, at 1.02 (delineating battery in the context of a malpractice claim).

61. Brown v. Rabbitt, 300 Md. 171, 175, 476 A.2d 1167, 1169 (1984).

62. *Id.* at 176, 476 A.2d at 1170.

63. MD. CTS. & JUD. PROC. § 3-2A-02(a) (1984).

64. Group Health Ass'n v. Blumenthal, 295 Md. 104, 453 A.2d 1198, 1205 (1983).

65. *See* Ralkey v. Minnesota Mining and Mfg. Co., No. 85-1254, slip op. at 9-10 (Md. App. June 6, 1985) (court accepted, without question, the parties' stipulation that this was the correct rule).

66. Lee v. Halikman, No. 84-215010/CL23635 (Circuit Court for Baltimore City, Oct. 22, 1984) (ruling that the third party defendant product manufacturer would have to be included in a health claims proceeding before the arbitration step could be considered completed); Wade v. Steinberg, HCA No. 83-18 (health claim panel chairman refused to dismiss a third party complaint against a drug manufacturer).

67. Group Health Ass'n v. Blumenthal, 295 Md. 104, 112, 453 A.2d 1198, 1203 (1983).

tion v. Blumenthal,[68] for example, the court reasoned that the patient's *respondeat superior* claim against a nonhealth care provider was arbitrable because "the aggregate of operative facts is still the alleged malpractice of the health care provider."[69] In essence, the derivative liability being litigated was nothing more than a patient's claim that a health care provider had committed malpractice.

C. *The Arbitration Hearing*

Actions before the health claims arbitration panels are commenced by the filing of a claim with the Director of the arbitration office.[70] The Director, in turn, is responsible for serving a copy of the complaint on the health care provider.[71] The issue is joined by the defendant's filing of a responsive pleading.[72]

Once the claim has been filed and answered, the panel selection process begins. This process is initiated when the Health Claims Arbitration Office selects panel candidates from rosters kept by the Director's Office.[73] Candidates are selected randomly from the rosters.[74] The only exception to this random selection process is that an effort is made to include physicians who specialize in the same area of expertise as that practiced by the defendant health care provider.[75] Three separate lists of five candidates are prepared: attorneys, health care providers, and

68. *Id.*

69. *Id.* at 112, 453 A.2d at 1203.

70. MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-04(a) (1984); MD. ADMIN. CODE tit. I, § .03.01.03 (1984) [hereinafter cited as COMAR]. For a detailed study of the working of the Director's Office, see DEPARTMENT OF BUDGET AND FISCAL PLANNING, DIVISION OF MANAGEMENT ANALYSIS AND ACTIVITIES, MANAGEMENT ANALYSIS STUDY OF THE HEALTH CLAIMS ARBITRATION OFFICE AND SELECTED ASPECTS OF THE ARBITRATION PROCESS 16-34 (1984) [hereinafter cited as ARBITRATION OFFICE STUDY].

71. MD. CTS. & JUD. PROC. § 3-2A-04(a) (1984). The Director accomplishes this by obtaining service by the local sheriff's office. COMAR, *supra* note 66, § .03.01.05.

72. MD. CTS. & JUD. PROC. § 3-2A-04(a) (1984); *see also* COMAR, *supra* note 66, § .03.01.06. The answer must be filed "within the time provided in the Maryland Rules for filing a responsive pleading to a declaration." MD. CTS. & JUD. PROC. § 3-2A-04(a) (1984) (incorporating MD. R.P. 2-321).

73. MD. CTS. & JUD. PROC. § 3-2A-03 (1984); COMAR, *supra* note 66, § .03.01.04(A)(2) ("[t]he register shall be divided into the following three categories: (a) Members of the general public who are not attorneys, health care providers, or agents or employees of any insurance company or society, (b) Attorneys, (c) Health care providers, subdivided, if practicable, by recognized health care specialties"); *see also id.* § .03.01.07(A)(3) ("[i]f feasible, each category of the register also shall be divided into geographic areas based on the county in which the candidates reside").

74. COMAR, *supra* note 66, § .03.01.07(B)(1) ("[t]he director may prepare the list of panel candidates from each category so that it consists only of individuals residing in counties in which a court would have venue").

75. MD. CTS. & JUD. PROC. § 3-2A-03(b) (1984); The Director need only include such specialists when the defendant's response "states that the matter falls within one or more recognized specialties," and then only "if practicable." MD. CTS. & JUD. PROC. § 3-2A-04(b) (1984). COMAR, *supra* note 66, § .03.01.07(C).

laypersons.[76] These lists, containing the names and biographical data on each proposed panelist,[77] are then delivered to the parties.

Each side is allowed two peremptory strikes from the list.[78] Strikes are usually made in writing.[79] Additionally, strikes must be made within thirty days from the time the panel lists are dispatched.[80] It is not unusual for one of the attorneys involved to miss the deadline.[81] When this oversight occurs, the forgetful attorney's client is at the mercy of the other side's strikes.

Parties may also object to any or all proposed panel members for cause.[82] The Director can sustain the objection and remove the panel member, if he finds "a reasonable basis for the objection."[83]

Once a panel is selected, the proceedings are run by the panel chairman,[84] who is always the attorney.[85] He rules on preliminary motions, sets schedules, conducts conferences, and otherwise acts as hearing officer and judge.[86] These broad powers are conferred upon the chairman, regardless of the training or expertise possessed by the individual attorney. The two major powers conferred upon the panel chairman are the authority to enter a summary decision and the right to require a prehearing conference.

A 1985 amendment to the Act empowered panel chairmen to grant summary decisions.[87] Substantively, a summary decision is analogous to a summary judgment. Procedurally, there is a difference in how sum-

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76. MD. CTS. & JUD. PROC. § 3-2A-04(b) (1984). Before dispatching the lists to the parties, the Director must contact each proposed panelist to verify that there are no conflicts of interest and that the proposed panelist is available to serve. COMAR, *supra* note 66, § .03.01.07(B)(2). If one of these problems is uncovered, the Director must add a new name to the list and again check for conflicts and availability. *Id.* § .03.01.07(B)(3).
77. MD. CTS. & JUD. PROC. § 3-2A-04(b) (1984); COMAR, *supra* note 66, § .03 .01.07(C).
78. MD. CTS. & JUD. PROC. § 3-2A-04(c) (1984); COMAR, *supra* note 66, § .03 .01.07(D)(2).
79. COMAR, *supra* note 66, § .03.01.07(D)(2) (objections to panel members must be in writing and state the basis for the objections). The regulation further states that the Director "shall make the strikes for a party on failure of the party to return a list and for multiple claimants or health care providers on notice that they cannot agree on their stikes in a particular category." *Id.* § .03.01.07(D)(4).
80. *Id.* § .03.01.07(D)(2).
81. One is well advised to photocopy the biographical data and circulate it among one's clients, including the insurance company and/or self-insured hospitals, before making strikes. Not only do the clients often have valuable insights, or perhaps some personal knowledge of a potential panel member, but also they serve as an additional reminder to make strikes in a timely fashion.
82. COMAR, *supra* note 66, § .03.01.07(D)(2).
83. *Id.*
84. MD. CTS. & JUD. PROC. § 3-2A-05(c) (1984); COMAR, *supra* note 66, § .03 .01.08(B).
85. MD. CTS. & JUD. PROC. § 3-2A-05(c) (1984).
86. COMAR, *supra* note 66, §§ .03.01.08(B), .03.01.10(D).
87. 1985 Md. Laws 1245-46 (to be codified as MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-05(a)).

mary judgment is handled in the circuit courts and how summary decisions will probably be handled in health claim proceedings.[88] The amendment creates this apparent procedural dichotomy by its requirement that "all issues of law shall be referred by the director to the panel chairman. All issues of fact shall be referred by the director to the arbitration panel."[89]

The amendment thus assigns to the Director the duty of distinguishing issues of law from issues of fact. This alters the decisional law, which has steadfastly held that the director has no judicial powers.[90] In addition to expanding the Director's authority, the new subsection fails to state how and when it can be invoked. It is unclear whether a panel chairman may entertain a motion for summary decision for issues of law that arise after the Director has referred the case to the panel.

The amendment may displace decisional law only to the extent that it applies to issues of law that are included in the Director's initial referral to the panel chairman. This interpretation would be consistent with the accepted notion that the Director loses all control over a case once he has referred it to the panel.[91] Following this approach, the common law, which requires that a majority of the panel approve summary decisions,[92] would govern the resolution of all issues of law that arise after the referral by the Director.

A different interpretation of the amendment, however, is that a motion for a summary decision may be made any time an issue of law arises, but that motion would have to be referred, by the panel chairman, back to the Director. The Director would then decide if the issue is indeed one of law and not of fact, and then, if it is an issue of law, the Director would send it back to the panel chairman for decision. Although some may view the need for this referral to the Director as wasteful, under cannons of statutory construction, the judiciary is powerless to construe a statute without giving effect to all its terms.[93] Thus, given the plain, unambiguous language of the amendment in calling for referral by the Director, it is difficult to conceive of how to avoid a referral back to the

88. *See* MD. R.P. 2-501 (procedures governing summary judgments in the circuit courts).

89. 1985 Md. Laws 1245-46 (to be codified as MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-05(a)(1)).

90. *See* Attorney General v. Johnson, 282 Md. 274, 285-87, 385 A.2d 57, 64-65, *appeal dismissed*, 439 U.S. 805 (1978); Osheroff v. Chestnut Lodge, 62 Md. 519, 527-28, 490 A.2d 720, 724 (1985). In addition to the authority to distinguish issues of fact from issues of law, the new subsection also empowers the Director to "rule on all issues of law arising prior to the hearing that are not dispositive of the case." 1985 Md. Laws 1246 (to be codified as MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-05(a)(2)). Even though this authority is limited to instances "where a panel chairman has not been appointed," *Id.*, it clearly vests the Director with judicial power.

91. *See* ARBITRATION OFFICE STUDY, *supra* note 70, at 12.

92. *See* Stiffer v. Weiner, 62 Md. App. 19, 24-25, 488 A.2d 192, 194-95 (1985).

93. *See, e.g.*, Silbert v. State, 301 Md. 141, 153, 482 A.2d 483, 489 (1984); City of Baltimore v. Hackley, 300 Md. 277, 283, 477 A.2d 1174, 1177 (1984).

director for later arising motions for summary decision, unless such motions be deemed waived if not made before the initial referral by the director.

To facilitate the operation of the entire process, most panel chairmen have a prehearing scheduling conference,[94] at which deadlines are set for the closing of discovery and expert witnesses are named.[95] Also, a hearing date is selected.[96] The regulations further provide that prehearing conferences may be used to resolve "[a]ny other matters that may aid in expeditious consideration and determination of the claim."[97] The order produced by the prehearng conference "specifies the agreements made at the prehearing conference,"[98] and controls "subsequent consideration of the controversy."[99]

Next, discovery begins. All discovery must be completed within 270 days of the date all defendants are served.[100] Except for this deadline, all other discovery rules apply as in the circuit courts.[101] The panel chairman rules on all discovery disputes.[102]

After discovery, the appointed panel is convened on the designated date, and the parties present their cases. In most respects, these hearings resemble actual trials because each litigant must present his entire case to the arbitrators, complete with expert testimony.[103] A refusal to present evidence before the arbitration panel will result in a dismissal at the trial court level because the party has, "in effect, refused to submit to . . . arbitration" as required by the statute.[104]

Whether this line of reasoning will support the proposition that a failure to arbitrate part of a claim constitutes a waiver of that issue is currently unresolved. It is difficult, however, to understand why the

94. COMAR, *supra* note 70, § .03.01.10.
95. *Id.* § .03.01.10(C).
96. *Id.*
97. *Id.* § .03.01.10(C)(1)(g).
98. *Id.* § .03.01.10(D).
99. *Id.* COMAR provides that the order is binding unless "within 7 days after service of the order, a party submits to the Director written objections to the order specifying an error . . . unless, at the hearing, all parties and the chairman agree on modification of the order." *Id.*
100. MD. CTS. & JUD. PROC. § 3-2A-05(b)(2) (1984).
101. *Id.*; COMAR, *supra* note 70, § .03.01.09(B).
102. MD. CTS. & JUD. PROC. § 3-2A-05(b)(2) (1984); COMAR, *supra* note 70, §§ .03.01.08(B), .03.01.09(B).
103. MD. CTS. & JUD. PROC. § 3-1A-05(b)(1) (1984) (incorporating by reference *id.* §§ 3-212 through 3-217, 3-220); COMAR, *supra* note 66, § .03.01.11. With respect to the rules of evidence, the Act and the regulations specify that the arbitration panel is not "bound by the technical rules of evidence." MD. CTS. & JUD. PROC. § 3-2A-05(b)(1) (1984) (incorporating by reference *id.* § 3-214(b)); COMAR, *supra* note 66, § .03.01.11(D)(1); *see also* Letter from Walter R. Tabler to Aaron M. Levine, P.A. (May 19, 1981) (informal ruling by the Director of the Health Claims Arbitration Office that the Manual for Administrative Law Judges (1974) sets forth the "appropriate guidelines for hearing under the Act"), *reprinted in* DECISIONS & MATERIALS, *supra* note 20, at tab marked "References-Law, Regs., Rules, Cases."
104. Bailey v. Woel, 302 Md. 38, 45, 485 A.2d 265, 268 (1984).

unarbitrated issues should not be deemed waived. Although it is true that the *de novo* appeal guaranteed by the Act implies the right to a new proceeding, it should not be construed to justify reserving part of a case for an anticipated action to nullify in the circuit court. Withheld issues would not only lead to incomplete panel decisions, but there is always the possibility that new claims and theories could be used to ambush an unwary opponent in the circuit court. Additionally, if parties are not required to litigate all aspects of the case before the panel, actions to nullify will be more likely because a complete resolution of the case at arbitration, which might have formed the basis of a settlement, has been rendered impossible.

At the close of the evidence, the panel renders its decision according to the guidelines set forth in the statute and the Code of Maryland Regulations.[105] This decision includes a finding as to liability, and if liability is found, the calculation of a dollar figure for damages.[106] Under the appropriate circumstances, these damages may include punitive damages and costs.[107] The panel must also include "an assessment of costs, including the arbitrators' fees," in its award.[108] As a final step, the panel is responsible for delivering its award to the Director's Office, which in turn serves the award on the parties.[109]

D. Appeals

The Act provides that either party "may reject an award for any reason" and take what is essentially a *de novo* appeal to the circuit court.[110] The procedures for rejecting a panel decision are well documented.[111] Either strict or substantial compliance with the rules is required, depending on which rule is at issue, or the right to appeal is lost.[112] First, a notice of rejection must be filed with the Director and the

105. MD. CTS. & JUD. PROC. § 3-2A-05(d) (1984); COMAR, *supra* note 66, § .03.01.12.
106. MD. CTS. & JUD. PROC. § 3-2A-05(d) (1984); COMAR, *supra* note 66, § .03 .01.12(C). In a case involving multiple parties, if the panel determines that one or more of the health care providers is liable, it must apportion responsibility and damages among the parties. COMAR, *supra* note 66, § .03.01.12(B-C).
107. Bishop v. Holy Cross Hosp., 44 Md. App. 688, 692, 410 A.2d 630, 632 (1980) (punitive damages).
108. MD. CTS. & JUD. PROC. § 3-2A-05(e) (1984); COMAR, *supra* note 66, § .03 .01.12(D). The rules governing the awarding of costs were reviewed by the court of appeals in Tabler v. Medical Mut. Liab. Ins. Soc'y, 301 Md. 189, 482 A.2d 873 (1984).
109. MD. CTS. & JUD. PROC. § 3-2A-05(f) (1984); COMAR, *supra* note 66, § .03 .01.12(E). The Director is empowered to return the award to the panel if the award is defective on its face. Osheroff v. Chestnut Lodge, Inc., 62 Md. 519, 490 A.2d 720 (1985).
110. MD. CTS. & JUD. PROC. § 3-2A-06(a) (1984); MD. R.P. BY1-BY5; COMAR, *supra* note 70, § .03.01.14(A). In an action to nullify, unless otherwise stated in the Act, the rules of civil procedure apply to all aspects of the case, including the pleadings. *See* Osheroff v. Chestnut Lodge, Inc., 62 Md. 519, 490 A.2d 720 (1985).
111. *See supra* note 110.
112. *See* Tranen v. Aziz, 59 Md. App. 528, 535-38, 476 A.2d 1170, 1173-75 (1984) (strict

arbitration panel and served upon the other parties and their counsel.[113] All this must take place within "30 days after the award is served upon the rejecting party."[114] Within the same 30-day period, the appealing party must also file "an action . . . to nullify the award" both in the circuit court and with the Director.[115] An action to nullify is the same as the filing of a complaint in an action at law.

Once an appeal has been properly noted, the action to nullify may proceed upon three fronts. First, the appellant can move to modify or vacate the award on procedural grounds. A motion to modify is appropriate when it is evident that the panel committed a mistake that can be remedied without affecting the substance of the award.[116] In contrast, a motion to vacate is appropriate when there is evidence that: (1) the award was procured by culpable acts of the parties; (2) the arbitrators were biased or committed similar prejudicial misconduct; (3) the arbitrators exceeded their power; (4) a postponement request was denied improperly; (5) prejudice resulted from a failure to conduct a hearing in the prescribed manner; (6) the arbitrators refused to hear evidence material to the controversy; or (7) there was no right to arbitration.[117] To preserve the right to modify or to vacate, the party asserting it must raise it by "pretrial preliminary motion." Otherwise, these procedural remedies will be deemed to have been waived.[118]

If a motion to modify or to vacate is granted, the court no longer sits in judgment of the arbitration decision. Rather, when a motion to mod-

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compliance), *cert. granted*, 301 Md. 471, 483 A.2d 754 (1985); Mitcherling v. Rosselli, 61 Md. App. 113, 121, 484 A.2d 1060, 1063 (1984) (substantial compliance). Although most of the rules employ the mandatory "shall," the sanction for failure to follow the rules is not always dismissal of the action to nullify. *Tranen*, 59 Md. App. at 534-36, 476 A.2d at 1173-74. Rather, dismissal is only warranted when the failure to follow the rules will result in the panel decision becoming a final judgment. *Mitcherling*, 61 Md. App. at 120-21, 484 A.2d at 1063; *see Tranen*, 59 Md. App. at 538, 476 A.2d at 1175.

113. MD. CTS. & JUD. PROC. § 3-2A-06(a) (1984); MD. R.P. BY2; COMAR, *supra* note 66, § .03.01.14. Service upon the panel members is mandatory, but a failure to effect such service does not warrant a dismissal of the action to nullify. Mitcherling v. Rosselli, 61 Md. App. 113, 118-21, 484 A.2d 1060, 1062-64 (1984), *cert. granted*, 303 Md. 20, 491 A.2d 586 (1985).

114. MD. CTS. & JUD. PROC. § 3-2A-06(a) (1984). As an exception to this rule, the Act states: "if a timely application for modification or correction has been filed [the notice of rejection must be filed] within 10 days after a disposition of the application by the panel." *Id.*

115. *Id.* § 3-2A-06(b); *see also* MD. R.P. BY2(a). This action to nullify, however, must be captioned and pleaded in conformity with the applicable rules of procedure. A failure to affix the proper caption will result in dismissal only if there is evidence that the opposing party was misled. Brothers v. Sinai Hospital, No. 85-1233, slip op. (Md. App. May 16, 1985). *See* Osheroff v. Chestnut Lodge, Inc., 62 Md. 519, 490 A.2d 720 (1985).

116. MD. CTS. & JUD. PROC. § 3-2A-06(c) (1984) (incorporating by reference *id.* § 3-223(b)).

117. *Id.* § 3-2A-06(c) (incorporating by reference *id.* § 3-224(b)(1-4)); *see also* Hartman v. Cooper's, 59 Md. App. 154, 474 A.2d 959 (1984) (articulating the bias standard).

118. MD. CTS. & JUD. PROC. § 3-2A-06(c) (1984).

ify is granted, and at least one of the parties still wants to proceed with the action to nullify, the modified decision becomes the decision in issue.[119] Similarly, when a motion to vacate is granted, the case proceeds "as if there had been no award."[120]

Second, an appeal may be taken from a granted motion for summary decision. If the motion was granted improperly, the Act appears to command that the panel's decision be vacated and that the trial of the case in the circuit court "proceed as if there had been no award."[121] One case, however, implies in dictum that, once the summary judgment is reversed, the claim can be remanded to the panel for arbitration.[122] This is troubling because no authority exists to justify remanding a claim to the arbitration panel. By contrast, the judicial review provisions in other arbitration and administrative acts expressly empower the circuit courts to remand cases to arbitrators and agencies.[123] It can be inferred that, by failing to grant circuit courts the authority to remand cases to health claims arbitration panels, the General Assembly intended to prohibit such remands.

Lastly, assuming that the award has not been vacated, the party who lost before the panel must rebut the presumption of correctness accorded the decision of the arbitration panel.[124] Because this presumption shifts the burden of proof,[125] it was the subject of an initial constitutional challenge to the Act.[126] The Court of Appeals of Maryland rejected an argument that the presumption violated the right to jury trial, and noted that "[t]his provision only establishes a rebuttable presumption. It cuts off no defense, interposes no obstacle to a full contestation of all the issues and takes no question of fact from either court or jury."[127] In short, the mere shifting of the burden of proof does not deprive the parties of the right to have their entire case evaluated by a jury.[128]

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119. *Id.*

120. *Id.*

121. *See Id.* (incorporating by reference *id.* § 3-224(b)(3-4)). This is consistent with a bill pending before the legislature to permit panel chairmen to enter summary decisions. SB16, 1985 Legislative term. Only the summary decision component of this bill was adopted as SB866, ch. 104, 1985 Md. Laws 1246.

122. *See* Stifler v. Weiner, 62 Md. App. 19, 25, 488 A.2d 192, 195 (1985). Apparently, the authority to remand is based on the need to exhaust the administrative remedy before the panel. *See* Oxtoby v. McGowan, 294 Md. 83, 91-92, 447 A.2d 860, 865 (1982); Schwartz v. Lilly, 53 Md. App. 318, 322-23, 452 A.2d 1302, 1304-05 (1982).

123. *See, e.g.*, MD. CTS. & JUD. PROC. § 3-225 (Maryland Uniform Arbitration Act); MD. STATE GOV'T CODE ANN. § 10-215(g)(1) (1984) (Administrative Procedure Act); MD. R.P. B13.

124. MD. CTS. & JUD. PROC. § 3-2A-06(d) (1984).

125. Hahn v. Suburban Hosp. Ass'n, 54 Md. App. 685, 692-93, 461 A.2d 7, 11-12 (1983); MD. R.P. BY5.

126. Attorney Gen. v. Johnson, 282 Md. 274, 385 A.2d 57, *appeal dismissed*, 439 U.S. 805 (1978).

127. *Id.* at 294-95, 385 A.2d at 69 (quoting Meeker v. Lehigh Valley R.R. Co., 236 U.S. 412, 430 (1915)).

128. Attorney Gen. v. Johnson, 282 Md. 274, 294, 385 A.2d 57, 69, *appeal dismissed*, 439

This presumption of correctness becomes important in two contexts. First, it shifts the burden of going forward. Hence, unless the party seeking to overturn the panel's decision rebuts the presumption by a preponderance of the evidence, a directed verdict will be entered against him.[129] A health care provider who was unsuccessful at the panel level therefore comes to the circuit court burdened with a presumption that he was negligent. Second, the presumption of correctness creates an incentive for plaintiffs to appeal the amount of a panel award in their favor. Once the jury is instructed that the panel should be presumed correct, plaintiff's counsel can attempt to use the panel's award as a floor from which to argue that additional compensation is warranted.

V. THE EXPERIMENT FAILS

The Maryland General Assembly created the health claims arbitration system in an effort to remedy the problems associated with the common law method of handling medical malpractice suits.[130] The investigation into these inadequacies did not occur overnight. A committee was formed, and the report it published became the genesis of the Maryland Act.[131] In the Maryland General Assembly, verbal and written testimony was submitted to a number of legislative committees, and several bills were drafted.[132] All sectors of the industry contributed to this search for an answer. Physicians, medical associations, spiritual healers, insurance carriers, and attorneys all presented their views of what should be done.

After sifting through this plethora of data, the Act's framers identified several goals that they believed could be achieved through arbitration. First, at the very least, the legislators expected arbitration to result in less crowded court dockets because malpractice claims would be relegated to an alternative forum.[133] Second, the presence of a health care provider and an attorney on the panel was designed to replace perceived juror irrationality with a working majority of dispassionate, level-headed experts. This, in turn, would reduce the number of meritless claims that

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U.S. 805 (1978). For a general discussion of the right to jury trial, see C. BROWN, INTRODUCTION TO MARYLAND CIVIL LITIGATION § 5.11 (1982).

129. Hahn v. Suburban Hosp. Ass'n, 54 Md. App. 685, 692-93, 461 A.2d 7, 11-12 (1983).

130. Many of these problems are outlined in Abraham, *supra* note 26, at 495-512.

131. The Committee was termed the Medical Malpractice Insurance Study Committee. It was appointed by the President of the Maryland Senate and the Speaker of the State's House of Delegates as a special task force on medical malpractice. 1976 REPORT, *supra* note 18, at 1. The report was published on January 6, 1976. A copy is available at the Maryland State Law Library, Courts of Appeal Building, Annapolis, Maryland (indexed Md. Y3.Ma 25:21B 1976).

132. The written testimony has been compiled in folders that are indexed under the bill numbers. These files are maintained by the Maryland Legislative Reference Service, located in the Legislative Services Building, Annapolis, Maryland.

133. 1976 REPORT, *supra* note 18, at 4; Abraham, *supra* note 26, at 514; Quinn, *supra* note 29, at 78; Weston, *Health Claims Arbitration — The View from the Panel Chairman*, MD. ST. B.J., June 1981, at 6.

were based solely upon impassioned pleas for juror sympathy.[134] Moreover, it was hoped that the removal of the sympathy element from the deliberative process, would result in considerably smaller awards than those given by juries.[135] Finally, the removal of frivolous claims from the system, combined with the informal rules of procedure and evidence applied in panel hearings, was designed to speed the access to justice for patients with bona fide claims.[136] In short, it was hoped that expert arbitration panels would have greater success in reaching fair results in malpractice cases.

Experience has shown, however, that the arbitration system has failed to meet its objectives. Rather than clearing malpractice claims from the court dockets, the arbitration system has merely served as an expensive hurdle that must be cleared before filing suit in court. According to recent reports, more than 50% of the cases in which panel hearings were held have been appealed.[137] The primary reason for this lack of finality is the Act's presumption of correctness. It fails to sufficiently deter appeals from panel decisions.

A defendant who loses a major case at the panel level loses little by appealing.[138] He risks only an increase, by the jury, of the panel's award. To the plaintiff, win or lose, there is no deterrent to appealing to the circuit court. If the plaintiff lost before the panel, the presumption of correctness will merely place the burden of proof where it would have been at common law, on the patient; whether by operation of the common law or by the Act, the patient has the burden of rebutting the presumption that the health care provider acted with due care.[139] If the patient won below, the size of the panel's award and the presumption of correctness can serve as a springboard to a substantially higher damages award by a jury.[140] Moreover, once the jury learns that the physician is

134. 1976 REPORT, *supra* note 18, at 1. One commentator believed that the attorneys' ability to manipulate the empathy of the jury was the "cause of this crisis." Comments of Doctors' Hospital of Prince George's County 3 (1976) (available in Maryland Legislative Reference File HB986C).

135. *See* Quinn, *supra* note 29, at 78-79; Shadoan, *Medical Malpractice Arbitration — Free at Last?*, MD. ST. B.J., Feb. 1981, at 5.

136. *See* LEGISLATIVE STUDY GROUP, ISSUE REPORT 3 (Feb. 18, 1976) (available in Maryland Legislative Reference File SB 436); MCGUIRK & RAFFERTY, *supra* note 26, at 15.

137. ARBITRATION OFFICE STUDY, *supra* note 70, at 14 LIEBMANN REPORT, *supra* note 11, at app. H; *see also* Editorial Comment, *Medical Malpractice Crisis, Cure or Merely the "Eye of the Storm?,"* 24 DEF. L.J. 175, 177 (1980) (commenting on the large number of appeals in Maryland).

138. LEGISLATIVE STUDY GROUP, ISSUE REPORT 6 (Feb. 18, 1976) (available in Maryland Legislative Reference File SB436).

139. *See* Paige v. Manuzak, 57 Md. App. 621, 641, 471 A.2d 758, 768 (1984).

140. Comments of the Medical Practice Action Committee, Inc. 2 (Feb. 2, 1976) (available in Maryland Legislative Reference File HB986). The fear is that the jury "will likely accept the panel's finding of negligence (the court must instruct the jury that such finding is presumed correct) and will, therefore, concentrate solely and exclusively on the issue of damages." *Id*; *see also* Statement of Kenneth S. Abraham, Esquire, Vice Chairman of the Maryland State Bar Association Special Committee

presumed to be negligent, the malpractice case is ultimately decided by the same "impassioned" jurors that the framers of the Act sought to exclude from the decision-making process; only now the jurors are told that they are to presume that the health care provider was negligent. Evidently, and not surprisingly, plaintiffs have become aware of this weakness in the arbitration system, because recent statistics show that plaintiffs are as likely to appeal awards in their favor as defendants are to appeal awards against the health care provider.[141]

Mounting evidence indicates that the Health Claims Arbitration Act has created a climate that encourages the filing of malpractice suits. A surge in the number of malpractice claims being filed since the advent of arbitration reflects this development. For example, the average annual number of claims filed at common law was between 50 and 60 per year.[142] According to the latest statistics, over 550 new health claims were filed in 1983 alone.[143] In a recent report, the Department of Budget & Fiscal planning cautioned that 86% of all cases filed in the health claims arbitration office are resolved through the arbitration process without appeal.[144] This figure is deceptive because it implies that all these claims were meritorious. Quite the opposite was actually true. Of these cases, 35% were dismissed and 39% settled.[145] Only 24%, or 182 of the 774 cases filed with the arbitration office between 1976 and January 1, 1983 were actually concluded by panel hearing.[146] And actions to nullify were filed in 106 (over 50%) of these panel cases.[147] Thus, the panel hearing process itself, when called upon to resolve a dispute, failed in more than half of its attempts. Not only are more cases being filed, but a higher percentage of these cases are being decided in favor of plaintiffs. At common law, defendant health care providers prevailed in 80% to 90% of the cases.[148] The latest statistics reveal that, under the arbitration system, plaintiffs now win approximately 42% of the cases.[149] Clearly, a heightened expectation of winning encourages the indecisive, putative claimant to file suit.

The prospect of a large award from the arbitration panel adds to

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to Consider Problems Related to Medical Malpractice in Maryland 3-4 (1976) (available in Maryland Legislative Reference File HB986).

141. LIEBMANN REPORT, *supra* note 11, at app. H.

142. *Id.* at 14; 1976 REPORT, *supra* note 18, at 7; LEGISLATIVE STUDY GROUP, ISSUE REPORT (Feb. 18, 1976) (1973 and 1974 statistics) (available in Maryland Legislative Reference File SB436). For the years 1970-75, an average of just over 60 malpractice claims per year were filed in Maryland courts against hospitals, physicians, and surgeons.

143. LIEBMANN REPORT, *supra* note 11, at app. F. There is evidence that this surge in litigation is not limited to Maryland. Middleton, *supra* note 38.

144. ARBITRATION OFFICE STUDY, *supra* note 70, at 14.

145. *Id.* at 9 (2% were settled during the hearing).

146. *Id.*

147. *Id.* at 14 (statistical breakdown on what happened to cases "Appealed from Health Claims Arbitration").

148. LIEBMANN REPORT, *supra* note 11, at 15; 1976 REPORT, *supra* note 18, at 7.

149. LIEBMANN REPORT, *supra* note 11, at 15.

these temptations to litigate. Rather than adopting the miserly approach that the Act's framers hoped the arbitrators would take, panel members are considerably more generous than their juror counterparts.[150] Furthermore, since the advent of arbitration, the State has witnessed a record number of panel awards in excess of one million dollars.[151] In short, not only have the panels been more likely to find health care providers negligent, but they also appear inclined to award more generous compensation.

Perhaps the most glaring problem with the State's approach to arbitration is its failure to provide patients with swift access to justice. First, due in part to a backlog in the system, it is not uncommon for the arbitration process to drag on for upwards of eighteen months from the time a claim is filed until the arbitration process is concluded.[152] This period of time adds to the average two years of investigation and preparation that precedes the filing of most claims.[153] Hence, without an appeal, an injured patient, who is often saddled with high medical bills and a disability that prevents him from working, must wait more than three and one-half years before obtaining a remedy.

Second, because appeals from panel decisions occur in more than half of the cases that are decided by the panel, the patient's wait frequently does not end with the panel's decision. Instead, for the reasons outlined above, panel decisions too often wind up in circuit court to be tried *de novo*. As a result, the waiting period is extended until the matter has been litigated in court. And, according to data supplied by the Maryland Administrative Office of the Courts, comparable negligence cases must wait an average of nineteen months before coming to trial.[154] Thus, at this time, the injured patient cannot count on having his injuries redressed for at least seven years.

Both sides pay a high cost for playing this waiting game. Because hearings before the arbitration panels are tried as though they were being litigated in court, all the expenses alluded to at the beginning of this article must be incurred. The litigants must retain experts to testify, conduct investigations, take depositions, and wage discovery battles. Moreover, litigants must incur these astronomical expenses twice: once at the panel level and again when the entire case is retried *de novo* in the circuit court. In an action to nullify, the same, if not more, experts must be retained and discovery disputes are reopened. Understandably, there is a sizable financial incentive to settle.

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150. *Id.* at 13-14.

151. *Id.* at app. P; DECISIONS & MATERIALS, *supra* note 20. For a summary of the size of pre-arbitration verdicts, see LIEBMANN REPORT, *supra* note 11, at app. S. These large verdicts are reflected in a nationwide rise in awards. Middleton, *supra* note 38, at 9-10.

152. LIEBMANN REPORT, *supra* note 11, at 12-13. For an explanation of the causes of this delay, see ARBITRATION OFFICE STUDY, *supra* note 70, at 8-13.

153. LIEBMANN REPORT, *supra* note 11, at app. N.

154. ARBITRATION OFFICE STUDY, *supra* note 70, at 11.

All of these problems have resulted in a system fraught with delay and duplication, a system with which no one is satisfied. Large panel awards coupled with a high plaintiff success rate have done little to discourage the filing of frivolous malpractice suits. Indeed, recent findings show that the arbitration system has actually contributed to the filing of such suits.[155] More importantly, the experiment has failed to keep a significant number of malpractice cases out of court. Frequent appeals have resulted in health care providers and their insurers again being subjected to the vagaries and inequities of the common law. Now, however, the health care providers are statistically less successful than they were before arbitration.

VI. PROPOSED SOLUTIONS

Over the last few years, it has become increasingly apparent to a number of critics that Maryland's health claims arbitration system is failing to achieve its goals. The Act's detractors have armed themselves with proposals that range from making minor procedural revisions to scrapping the entire arbitration system.[156] To understand these suggested changes, each must be examined separately in terms of the justifications for creating health claims arbitration.

A. Modification of the Panel Makeup

Common sense dictates that the quality of a health claims arbitration decision is only as high as the capability of the panel called upon to make it. It is the panel members who must sift through the evidence and arrive at a decision. If they are unqualified or lack the guidance of specific standards, both the parties and the system suffer from erroneous and inconsistent decisions. The appealing party incurs the burden of arguing that a decision, which the jury is told is presumptively correct, is actually wrong. Also, the system loses because, in the eyes of the legal community and the public, its results appear arbitrary and inconsistent. The public perceives that the arbitration system has failed to find the truth, and more importantly, that it has failed to achieve justice.

Because panel members are volunteers, it seems ungrateful to criticize their performance. Yet, perhaps because the job is voluntary, the Director of the Health Claims Arbitration Office has experienced consid-

155. LIEBMANN REPORT, *supra* note 11, at 14.

156. A number of panels and commentators have criticized the Act and encouraged either its abolition or modification. *See, e.g.*, ARBITRATION OFFICE STUDY, *supra* note 70, at 34-47 (modification); Medical Malpractice Task Force (1983) (modification) [hereinafter cited as MCGUIRK REPORT]; King, *Suggested Amendments to the Health Claims Arbitration Act*, MD. ST. B.J., Feb. 1981, at 4 (modification); King, *The Health Claims Arbitration Act: Is it a Rose?*, MD. ST. MED. J., Sept. 1982, at 38, 40 (abolition); MARYLAND STATE BAR ASS'N, REPORT OF SPECIAL COMMITTEE ON HEALTH CLAIMS ARBITRATION app. A (1984), *reprinted in* 89 TRANSACTIONS 133, 143 (1984) (abolition) [hereinafter cited as MSBA]; Weston, *supra* note 133, at 8.

erable difficulty in attracting qualified medical and legal professionals to hear panel cases.[157] Furthermore, the lists of lay persons prepared by the Director bear no resemblance to jury lists. This is because the names are assembled from applications filed by lay persons interested in serving on panels. Thus, the lay panel member lists are not representative of a cross-section of the community.

1. The Professionals on the Panel

A number of solutions have been proposed to improve the panel recruitment process. Before examining them, it is important to recognize the purposes for a health care provider and an attorney on the panel. Neither of these professionals is there to advance the respective interests of his or her profession. Rather, their presence exists to provide the expertise necessary to unravel the complexities of the case.[158] The health care provider should offer insight into the medical complexities. In a complicated case, however, a health care provider who does not practice the same specialty as the defendant is often of limited use to the panel. For example, most pediatricians would be less than qualified to assist the other panel members in a case involving allegations of negligent failure to diagnose adult lung cancer. Clearly, the panel would be better served by a trained oncologist.

As panel chairman, the attorney's skill and qualifications are especially important because he must preside over the panel hearing and resolve all issues of law.[159] Additionally, the complexity of malpractice cases, coupled with the level of experience prevalent among attorneys who litigate them, suggest that only highly trained panel chairmen should be selected. Hence, he must not only be learned in the law of the case, he must be a sophisticated jurist as well.

A recent special report of the Maryland State Bar Association[160] recommended that attorneys and health care providers be drawn from lists of those licensed to practice these professions.[161] Once selected for duty, the professional would be required to serve, unless "good cause to the contrary is shown by the [professional]."[162] This proposal overlooks two important considerations. First, it does not attempt to identify panel members who have the skills needed to make a meaningful contribution to the case. Instead, under the Bar Association proposal, the candidates are to be selected at random from each of the professional pools.[163] As a result, panels may be made up of health care providers who have little

157. *See* LIEBMANN REPORT, *supra* note 11, at 28; MCGUIRK REPORT, *supra* note 156, at 1; King, *The Health Claims Arbitration Act: Is it a Rose?*, *supra* note 156, at 39; MSBA, *supra* note 156, at 133-34.
158. *See supra* note 48 and accompanying text.
159. *See supra* note 47.
160. MSBA, *supra* note 156.
161. *Id.* at 134, 136-37.
162. *Id.* at 134.
163. *Id.* at 136.

knowledge about the medical specialty in question, and attorneys who have no experience in malpractice litigation, let alone the training necessary to be a good judge. Under the Bar Association proposal, there would be an increased likelihood both that the panel would fail to understand the medical issues, and that the attorney's inexperience would produce a wealth of appeals on procedural questions.

A more effective approach to the professional panel member recruitment problem is to identify health care providers and attorneys who can effectively fulfill their respective roles.[164] With regard to health care providers, the recruitment effort must be aimed at identifying and soliciting health care providers who share the defendant's specialty.[165] If volunteers do not come forward, a budget should be created to compensate these experts.[166] The expenses incurred by the fund should be taxable as costs against the parties.[167]

The attorney should also be selected from a pool of applicants who have the appropriate qualifications: knowledge of malpractice law and judicial training.[168] These skills should be acquired through actual court experience, though some classroom or seminar training might be used to ameliorate lack of experience. Once selected and trained, these quasi-judicial arbitrators would be massed into a pool that could be drawn upon when the need arises, much like the equity master system currently in force.[169]

Second, the Bar Association errs in suggesting mandatory service by health care providers and attorneys on health claims arbitration panels.[170] Aside from reflecting a certain amount of naiveté about the practicalities of the respective professions, the suggested system of drafting professionals to serve on panels would certainly involve persons who would be as unconcerned about health claims arbitration generally as they would be about the merits of the individual case to which they are

164. This is done in a number of states. *See, e.g.*, ALASKA STAT. § 09.55.535(g) (1983); N.Y. CIV. PRAC. LAW § 148-a(2) (McKinney 1983); UTAH CODE ANN. § 7001 (Supp. 1984).

165. The Maryland Act provides that the Director should make an effort to "include persons in the specialty on the list [of panel candidates] from the health care provider category." MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-04 (1984).

166. Many states compensate on a *per diem* basis. *See, e.g.*, TENN. CODE ANN. § 29-26-109(a) (1980); VA. CODE § 8.01-581.10 (1984); WIS. STAT. ANN. § 655.03(3)(c) (West Supp. 1984-85).

167. The Bar Association of Baltimore City requested that all panel members be professional arbitrators. Letter from Geoffrey S. Mitchell to the Honorable Joseph Owens (March 31, 1976) (available in Maryland Legislative Reference File HB986).

168. It might be wise to limit the pool to retired members of the judiciary. Under the health claims arbitration statutes in other states, only judges or retired judges serve as panel chairmen. *E.g.*, N.Y. CIV. PRAC. LAW § 148-a (McKinney 1983); VA. CODE § 8.01-581.3(ii) (1984). In Maryland, though, the active judge is precluded by the canons of judicial conduct from serving on an arbitration panel. MD. R.P. 1231, Canon XXV.

169. *See* MD. R.P. 2-541.

170. MSBA, *supra* note 156, at 134, 136.

involuntarily assigned. This minimum effort attitude would not only rob the panel of the meaningful insight of the professional, but, without a careful appraisal of the merits of a given case by the health care provider or attorney, the likelihood of erroneous decision would be increased substantially. Moreover, absent a plan to select only those arbitrators who can unravel the complexities of an individual case, the compulsory panel member's expertise could easily be wasted on a case involving an unrelated specialty. The Bar Association would require highly specialized professionals to serve on panels with no guarantee that they would be able to contribute anything more to the panel's decision than the lay panel member.

Rather than the Bar Association's involuntary arbitrators, what is needed is a rethinking of the existing voluntary service system. An intensive and expansive public relations campaign might net a handful of qualified professionals. Retired judges, medical and law school professors, and senior attorneys would be the best targets of this recruitment drive. It is unrealistic, however, to expect that most health care providers and attorneys will serve purely as volunteers.[171] The compensation provided for these specialists could take either the form of monetary remuneration or credit toward certification as a specialist. Monetary remuneration could be structured to track the fee system in existence in the given profession.[172] Nurses would be paid the market rate for nurses, doctors the market rate for doctors, and attorneys the market rate for attorneys. The funding for these fees could be apportioned among the parties as costs, paid for out of general revenues, or both.[173]

2. The Layman on the Panel

Under the current system, anyone who volunteers to serve as a panel member will usually be allowed to sit. The result of this purely voluntary system is that, unlike jurors, lay panel members are not representative of the community at large.

In contrast to the professional members of the panel, the lay member is supposed to lack any specific skill or expertise in medicine or law. Indeed, the Health Claims Arbitration Act expressly precludes health care providers and attorneys from filling the seat of the lay panel mem-

171. According to a recent report of the Maryland State Bar Association, the current Director of Maryland's Health Claims Arbitration Office admits the failure of the all-volunteer system. MSBA, *supra* note 156, at 134; *see also* ARBITRATION OFFICE STUDY, *supra* note 70, at 35 (noting that Director's major problem is that panel members are unavailable to serve when contacted).

172. For a sampling of the different *per diem* schedules, see *supra* note 166.

173. Costs are apportioned in this manner under the current system. COMAR, *supra* note 70, § .03.01.12(D). Some states concur, *see* VA. CODE § 8.01-581.10 (1984), and some differ, *see* PA. STAT. ANN. tit. 40, § 1301.304 (Purdon Supp. 1984) (health care providers finance the arbitration panels); S.D. COMP. LAWS ANN. § 21-25B-25 (1979) (costs paid out of general funds). *See supra* note 166 (detailing approaches taken by other states).

ber.[174] In contrast to the problems associated with requiring professionals to serve on panels, a compulsory system for selection of the laymen *can* produce qualified panel members. In fact, a similar compulsory system has worked in other contexts for centuries in the form of compulsory jury service.

Recognizing these considerations, the Bar Association concludes that lay panel members should be drawn from the jury lists kept by the circuit courts.[175] Once selected, the lay members would be compensated at the same rate paid to jurors.[176] So long as persons selected for panel work were given credit for jury service, requiring them to serve on arbitration panels would work no hardship upon them. In essence, the lay panel designees would be in the same position as if they had been called for jury service.

B. Discovery

Much has been written in recent years about the abuses of the rules of discovery.[177] First, discovery is costly. Stenographic costs for depositions alone often runs into thousands of dollars for each side. Second, skirmishes frequently take place over what is properly discoverable and what can properly be protected.

Medical malpractice cases are no exception. With both sides consulting and calling sophisticated experts and lay witnesses, and the large amount of documentary evidence, extensive use of discovery and discovery disputes frequently occur in malpractice cases.[178] Like all legal disputes, these squabbles cause higher costs to the parties and, more importantly, delay. Because of the duplicative system created by a *de novo* appeal to the circuit courts, the Health Claims Arbitration Act has exacerbated the problems with discovery by multiplying discovery disputes. Also, because discovery conducted at the arbitration level is not binding on the parties in the circuit court, discovery is reopened when an action to nullify is filed.[179] Litigants must depose newly called experts, and may relitigate, at trial, discovery disputes lost at the panel level.

One way to cut the cost and delay imposed by dual discovery is to make discovery at the panel level binding upon the parties in the circuit

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174. MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-03(c) (1984); COMAR, *supra* note 70, § .03.01.07(A)(2)(a).

175. MSBA, *supra* note 156, at 137. It should be noted, however, that the current juror stipends are ridiculously out of touch with the market rate for a working person's time.

176. *Id.*

177. For a recent symposium on the topic, see *National Conference on Discovery Reform*, 3 REV. LITIGATION 1 (1982).

178. The Act, however, limits the period for discovery to 270 days. MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-05(b)(2) (1984).

179. This is a result of the *de novo* review accorded health claims cases in the circuit court. *See supra* note 116.

court.[180] In other words, it could be made very difficult for parties to name new experts or to conduct additional discovery in the circuit courts. For example, these tactics might be limited by requiring a showing of prejudice or substantial injustice before new experts could be named. This, of course, would have the effect of forcing all sides to pull out all the stops, as it were, and hold nothing back at the arbitration level. Unnamed experts and concealed discovery tactics could not be saved for an anticipated trial in the circuit courts.

By compelling the parties to complete their discovery before the panel, this proposed limitation closely resembles a typical non-*de novo* appeal from an administrative tribunal. Although the parties would be free to appeal on the evidence in the record, they would not be free to supplement the record with evidence concealed from the arbitrators. As a consequence, panels would be presented with more complete records and parties would not have to fear being ambushed at a later date by the use of new evidence in the action to nullify.

A flaw in this reasoning is that it assumes that the arbitration level is the best place to resolve a malpractice dispute. Unfortunately, history reveals that of the cases that have been fully litigated and decided by panels, many are appealed. By providing for a *de novo* appeal, the General Assembly has, in effect, removed a major incentive to accept the finality of an unfavorable health claims decision. Because there is a constitutional right to a jury trial, a standard of review that accorded more deference to a panel's decision would likely be declared unconstitutional.[181] With this constitutional limitation in mind, requiring a complete and unrestrained litigation of malpractice suits before arbitration panels may represent a misconception of the forum in which the case must ultimately be decided.

C. *Certificate of Merit*

A difficulty that plagued the circuit courts under the common law, and one that continues under the present arbitration system, is the problem posed by frivolous claims.[182] These claims are filed with little hope of success. Instead, it is hoped that the defendant's insurance carrier will settle for a sum below the cost of having the claim dismissed.

Under the current system, it is very simple to play this game. Once a claim is filed, discovery proceeds and costs mount. Often, it is only after this expensive discovery process that the defendant will learn of the fatal weaknesses in the plaintiff's case, or, more importantly, that the

180. *See* LIEBMANN REPORT, *supra* note 11, at 30.

181. *See supra* notes 124-26 and accompanying text. Other states have gone further and completely barred any mention of the arbitration panel's decision. *See* MONT. CODE ANN. § 27-6-704 (2) (1983). Indeed, some states declare that the panel's decision is made without authority and therefore is non-binding. *See* N.M. STAT. ANN. § 41-5-20(f) (1978).

182. *See supra* text accompanying note 155; LIEBMANN REPORT, *supra* note 11, at 14-16.

plaintiff has no expert. Indeed, the current rules of discovery do not require the naming of an expert until it is requested in discovery.[183] As a result, a claim can be filed before the plaintiff has even had a physician's opinion on the merits of the case.

A number of commentators have called for the adoption of a certificate of merit requirement to eliminate some of this abuse.[184] Under this rule, a plaintiff would have to obtain the opinion of an expert before filing suit. The expert would have to certify, under oath, that he has reviewed the merits of the case and concluded that there is probable malpractice. Of course, the certificate would not be required in cases where malpractice could be proved without the aid of expert testimony.[185]

The certificate of merit requirement is a good idea. It is true that it imposes the added cost of hiring an expert before a case is filed, and there is a possibility that this added cost could raise the cost of settlement. The cost of the expert, however, is one which the serious plaintiff must bear sooner or later. The certificate requirement merely mandates that the expert be retained sooner. In addition, with Maryland's rejection of the strict locality rule, finding an expert should not prove to be a difficult chore.[186] Thus, the certificate of merit proposal will fulfill its purpose by forcing the plaintiff to test the merits of his case on an expert before he tests them on the panel.

D. The Collateral Source Rule

Although it is only tangentially related to malpractice cases, the collateral source rule has become an issue in the current fight to amend the Health Claims Arbitration Act. The rule is a fairly simple one, requiring that any monies received from the injured party's insurer cannot be offered by the defense to reduce damages.[187] In short, a defendant cannot urge the trier of fact to subtract from its award any amount received by the patient from his own insurer.[188] The reason behind the rule is that plaintiffs should not be penalized, and defendants should not be unjustly enriched, simply because the plaintiff was prudent enough to purchase insurance.[189] The practical effect is that the plaintiff is allowed to recover

183. MD. R.P. 2-402(e).

184. Letter from John J. Sellinger to Chairman V. Mike Miller, Jr. and Members of the Senate Judicial Proceedings Committee (April 6, 1984) (available in Maryland Legislative Reference File SB1003/HB1527); Addendum to letter from William I. Weston to The Honorable Thomas V. Mike Miller and the Members of the Judicial Proceedings Committee (March 1, 1984) (available in Maryland Legislative Reference File SB1003/HB1527).

185. *See supra* note 8 and accompanying text.

186. *See supra* notes 33-37 and accompanying text.

187. American Paving & Contracting Co. v. Davis, 127 Md. 477, 96 A. 623 (1916); Baltimore City Passenger Ry. v. Baer, 90 Md. 97, 44 A. 992 (1899).

188. Abraham, *supra* note 26, at 504-05.

189. 3 DAMAGES IN TORT ACTIONS § 17.00 (M. Minzer ed. 1984).

twice: once from his insurer and a second time from the defendant.[190]

The proponents of change argue that the collateral source rule should be eliminated in malpractice suits so that costs might be reduced.[191] Because malpractice is an area in which the costs have already exceeded all reasonable limitations, these proponents of change argue that the collateral source rule gives an unaffordable windfall to plaintiffs.[192] In addition, they attack the rationale for the rule. They argue that patients, when purchasing insurance, do not assume that they will be the victims of malpractice. Because they assume that their doctor will conform his conduct to the applicable standard of care,[193] patients will continue to buy health insurance, regardless of whether the collateral source rule applies to malpractice suits.

Encouraging the purchase of insurance, however, is only part of the justification behind the collateral source rule. The remaining justification for the rule, that the defendant should not benefit from the plaintiff's foresight in obtaining insurance, remains unaddressed. If the collateral source rule is completely repealed, the negligent physician will be enriched by the patient's health insurance.

This is unjust for two reasons. First, the proponents of change can point to no reason for carving out an exception to the collateral source rule for malpractice plaintiffs. It is true that the costs of litigation are exorbitant; however, they are exorbitant in other areas of the law as well. The arguments based on the unfairness of the plaintiff's double recovery in a medical malpractice case are nothing more than a restatement of the arguments against the collateral source rule in general.[194] There is no compelling reason for excepting malpractice suits from the rule's scope.

Second, there is no reason why the negligent physician should not be responsible for the entire injury he has caused. One of the central themes of tort law is that the one who negligently causes an injury should pay the claim.[195] Thus, it is unfair to ask the plaintiff's insurer to pay a claim for which it bears no responsibility, while the responsible party is saved that part of his or her costs.

The more equitable solution is to place the entire cost of the loss on the defendant and his malpractice insurer. Malpractice law is aimed at compensating patients, not enriching them. Accordingly, the problem

190. It should be noted, however, that most health insurance policies contain subrogation clauses that permit the insurer to recover any amount it has paid the insured.

191. Abraham, *supra* note 26, at 505-06.

192. *See id.*; Comment, *supra* note 28, at 668-69.

193. Comment, *supra* note 28, at 666.

194. DAMAGES IN TORT ACTIONS, *supra* note 177, § 17.04; Statement of Kenneth S. Abraham, Esquire, Vice Chairman of the Maryland State Bar Association Special Committee to Consider Problems Related to Medical Malpractice in Maryland 6 (Feb. 24, 1976) ("there is no reason to believe that the collateral source rule imposes a particular hardship on defendants in malpractice cases") (available in Maryland Legislative Reference File HB986).

195. PROSSER AND KEETON, *supra* note 9, § 2.

can be solved by awarding a full judgment against the defendant. The plaintiff would then be required to repay his insurer any payments received from that insurer, to the extent that the recovery from the errant physician was sufficient to cover them. Because the plaintiff litigated the case for the benefit of his insurer, a pro rata share of the litigation costs could be subtracted from this payment to the insurer. Under this system, the plaintiff would be compensated, his insurer would break even, and the defendant would bear the full cost of his negligence.

E. Rules of Evidence

In general, arbitration is praised for its informality. Not everyone, however, praises this lack of structure.[196] Because the panels are not bound by the formal rules of evidence, they can consider evidence that could never be admitted at trial.[197] Proponents argue that this flexibility allows the arbitrators to consider a wide range of information in their search for the truth.[198] Moreover, the two knowledgeable experts on the panel are less likely to be as improperly influenced by otherwise inadmissible evidence as jury members would be if they were to view the same evidence.

Yet, just as flexibility opens the door to more information, it also creates a situation where the panel decision can be based on evidence that would be inadmissible in court. For example, because panel hearings are not governed by the technical rules of evidence, it is conceivable that a panel's decision could be based solely on hearsay evidence.[199] The problem is that, although the evidence is not admissible in court, the panel decision is, and the jury is instructed that it is presumed to be correct.[200] Thus, the party bringing an action to nullify the panel decision is placed in the uncomfortable position of having to rebut a presumption that would not exist if the rules of evidence had been enforced at the panel level.[201]

To remedy this problem, some critics argue that the rules of evi-

196. *See* LIEBMANN REPORT, *supra* note 11, at 26-27; MSBA, *supra* note 156, at 141-42.
197. *See supra* note 103.
198. *See supra* note 103 (letter from the current Director); Letter from William I. Weston to The Honorable Thomas V. Mike Miller and Members of the Judicial Proceedings Committee (March 1, 1984) (available in Maryland Leglislative Reference File SB1003/HB1527).
199. Under accepted administrative law principles, "not only is hearsay evidence admissible in administrative hearings but . . . such evidence, if credible and of sufficient probative force, may indeed be the sole basis for the decision of an administrative body." Tauber v. County Bd. of Appeals, 257 Md. 202, 213, 262 A.2d 513, 518 (1970) (quoting Eger v. Stone, 253 Md. 533, 542, 253 A.2d 372, 377 (1969)); *see also* Redding v. Board of County Comm'rs, 263 Md. 94, 110-11, 282 A.2d 136, 145 (1971). Whether a health claims arbitration panel is governed by administrative common law has yet to be expressly decided. One case, however, suggests that it would apply by analogy. *See* Oxtoby v. McGowan, 294 Md. 83, 91, 447 A.2d 860, 865 (1982).
200. *See* notes 124-28 and accompanying text.
201. Comment, *supra* note 28, at 681.

dence should be applied in proceedings before the panels.[202] Undoubtedly, this would remedy the problem created by having a panel decision introduced that is based on inadmissible evidence. Also, it would provide a formalized set of rules to guide panel chairmen.[203] Another way to avoid admitting into court a panel decision that is based on inadmissible evidence is to simply prohibit any mention of the panel's decision in court.[204]

Both of these proposals may create more problems than they solve. First, the application of the rules of evidence to arbitration hearings will only obscure the search for the truth, and destroy the existing informality. Second, if complaints concerning the lack of judicial training among panel chairmen are at all founded, there will surely be a large number of appeals based on erroneous evidentiary rulings. Although the existing Act contains no mechanisms to explain how the circuit court should dispose of erroneous evidentiary rulings by panel chairmen, it is likely that the court would vacate the panel decision and proceed as though there had been no arbitration hearing.[205] In other words, all the funds and efforts devoted to arbitrating would be lost because of a technical error. Evidentiary rulings should be left to those who are trained to make them: the trial court judges.

Third, prohibiting any mention in court of the product of an arbitration hearing would destroy what little value the current arbitration system has as a mechanism for resolving disputes. It is difficult enough under the existing system to rationalize requiring parties to litigate a case before the arbitration tribunal, only to obtain a presumption of correctness in the circuit court. Removal of the presumption would be a removal of the already inadequate reward for arbitrating. There would be no reason to settle in the face of an unfavorable ruling; at worst, all that could occur in the circuit court is that the jurors would reach the same conclusion as the panel. Also, it is difficult to justify requiring parties to incur the enormous expenses associated with litigating a malpractice case and then deny them the opportunity to use the decision. Barring any

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202. *See, e.g.*, LIEBMANN REPORT, *supra* note 11, at 26; MSBA, *supra* note 156, at 141-42. Some states apply the rules of evidence. *See, e.g.*, GA. CODE ANN. § 9-9-126 (1982); PA. STAT. ANN. tit. 40, § 1301.506 (Purdon Supp. 1984). One report even advocates that the arbitration office devise its own rules of evidence. ARBITRATION OFFICE STUDY, *supra* note 70, at 41.

203. MSBA, *supra* note 156, at 141-42.

204. Some states adopt this position. *See, e.g.*, MONT. CODE ANN. § 27-6-704 (1983); N.M. STAT. ANN. § 41-5-20(D) (1978); *see also* PA. STAT. ANN. tit. 40, § 1301.506 (Purdon Supp. 1984) (permits the admission of the award, but not the damages awarded).

205. Although the issue has yet to be resolved, it is unlikely that a circuit court has the authority to remand a case to a health claims arbitration panel. *See supra* notes 113-15 and accompanying text. If no authority exists to remand, the circuit court would have to vacate the panel's decision. *See* MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-06(c) (1984).

mention of the panel's decision in court, therefore, reduces health claims arbitration to nothing more than a costly advisory opinion.

F. Voluntary Arbitration by Waiver

Among the more hotly debated proposals to amend the Maryland statute is one to allow the parties the option of waiving arbitration and filing in court.[206] Because the consent of both parties would be required to waive arbitration, each litigant would have the option of requiring that the case be submitted to arbitration.[207] This would remove cases from the jurisdiction of the arbitration network that the parties agree would be better handled by the courts.[208]

This proposal would provide a vehicle for circumventing the primary purpose of the requirement for medical malpractice arbitration: to provide a framework for dispute resolution outside of the trial court. Additionally, because of the low level of deference accorded health claims arbitration decisions and because of the large number of appeals, it is unlikely, if waiver were permitted, that either party would select arbitration for any reason other than its value as a dilatory tactic. Thus, arbitration would become a device for delaying justice, not expediting it. Lastly, with the demise of compulsory arbitration, the court dockets would again be clogged with malpractice cases. To make arbitration voluntary is to abolish it, and to abolish it is to return to the problems encountered at common law.

G. Voluntary Arbitration by Contract

A handful of states have relegated the decision to arbitrate to the doctor and his patient.[209] These states accord legislative recognition to a pre-treatment contract executed by the physician and the patient. This contract calls for binding arbitration of all disputes arising out of the medical care received. These statutory schemes expand upon the common law principle that allows parties to bind themselves to arbitration.[210] Most of these modifications to the common law seek to ensure that the

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206. LIEBMANN REPORT, *supra* note 11, at 25-26; MSBA, *supra* note 156, at 140. The current bill is Senate Bill 156 (1985).

207. *See, e.g.*, ARIZ. REV. STAT. ANN. § 12-567(A) (1982 & Supp.); TENN. CODE ANN. § 29-26-104 (1980); VA. CODE § 8.01-581.2 (1984).

208. Letter from John J. Sellinger to Chairman V. Mike Miller, Jr. and Members of the Senate Judicial Proceedings Committee (April 6, 1984) (available in Maryland Legislative Reference File SB1003/HB1527).

209. ALASKA STAT. § 09.55.535 (1983); CAL. CIV. PROC. CODE § 1295 (West 1982); ILL. ANN. STAT. ch. 10, § 203 (Smith-Hurd Supp. 1984); MICH. COMP. LAWS ANN. § 600.5041 (West Supp. 1984); S.D. COMP. LAWS ANN. § 21-25B-1-4 (1979); VA. CODE § 8.01-581.12 (1984).

210. *See generally* MD. CTS. & JUD. PROC. CODE ANN. § 3-201 through 3-234 (1984) (Maryland's version of the Uniform Arbitration Act, which codifies the common law principles).

patient knowingly and voluntarily waives his right to have a jury resolve any disputes that might arise.

The Michigan health claims statute,[211] for example, requires that the patient be fully apprised of his rights, the most important of which is that signing the agreement cannot be a prerequisite to receiving treatment.[212] Moreover, the patient is allowed to revoke the agreement, in writing, within sixty days of its execution.[213] In emergency care situations, the agreement can be executed only after treatment has been rendered.[214]

This contractual approach avoids many of the constitutional problems that plague mandatory arbitration.[215] Because the parties execute the agreements between themselves, the courts have had little difficulty in sustaining the agreements as knowing and voluntary waivers of the right to a jury trial.[216] Furthermore, these agreements have been upheld because they do not rise to the level of a complete waiver of future claims; rather, the patient is merely opting to have his dispute heard in a substitute forum.[217]

Because there is no denial of the right to a jury trial, the panel decision can be accorded a greater degree of finality.[218] After a contract arbitration proceeding, the arbitrators' decision can only be appealed if it was rendered in violation of the rules of arbitration agreed to by the parties or if there is no support whatsover in the record for the arbitrators' findings of fact.[219] This is a major advantage over the duplicative procedure that exists when a *de novo* appeal is required.

Although the contract arbitration schemes have managed to clear many of the constitutional hurdles, they have been repeatedly criticized as representing the product of unequal bargaining power.[220] Thus far, these contract law challenges have been rejected when it was apparent that 1) the patients were fully apprised that they would be treated regardless of whether they signed, and 2) there was a complete disclosure of the rights being waived.[221]

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211. MICH. COMP. LAWS ANN. § 600.5042 (West Supp. 1984).
212. *Id.* § 600.5042(2).
213. *Id.* § 600.5041(3).
214. *Id.* § 600.5042(1).
215. Comment, *supra* note 28, at 685.
216. *See generally* Mengel, *The Constitutional and Contractual Challenges to Michigan's Medical Malpractice Arbitration Act*, 59 J. URB. LAW 319 (1982) (reviewing the constitutionality of the Act).
217. *Id.* at 330.
218. The Virginia health claims arbitration statute is an example of the different levels of deference that can be accorded. Virginia has adopted the non-binding arbitration for malpractice actions, unless there is an agreement to arbitrate. VA. CODE § 8.01-581.2 (1984). When an agreement has been executed, the arbitration findings are binding on the parties. § 8.01-581.12(c).
219. Prince George's County Educators' Ass'n v. Board of Educ., 61 Md. App. 249, 486 A.2d 228 (1985) (findings of fact); MD. CTS. & JUD. PROC. § 3-224.
220. Mengel, *supra* note 216, at 329-31.
221. *See, e.g.*, Jackson v. Detroit Memorial Hosp., 110 Mich. App. 202, 312 N.W.2d 212

In spite of the judiciary's willingness to affirm on these grounds, it is difficult to understand how these two considerations can remove the likelihood that the arbitration agreement could easily become a contract of adhesion. By definition, doctors are the masters of the doctor-patient relationship. Thus, when asked to sign an arbitration agreement, most patients comply willingly, without consulting counsel. The result is that an important right has been waived without a complete understanding of that right or of the benefit of counsel. Without a doubt, such a waiver would never pass muster in a criminal case.[222] Indeed, one has only to look to a recent survey conducted of patients in Michigan to see the popular misconceptions created by the public's failure to comprehend what it is surrendering.[223] For example, the survey found that 62.2% misunderstood their rights and 74.2% mistakenly believed that they could appeal the panel's ruling *de novo*.[224] Moreover, the offering personnel — the persons responsible for executing these contracts on behalf of patients — responded in large numbers that more than half of the patients they represented did not understand what was being waived.[225]

Another problem with contract arbitration is that it is not always fair to the physicians and hospitals. The rights created under the statutes almost always protect the patient.[226] For example, many acts allow the patient to revoke the contract within a given time period without creating a similar right for health care providers.[227] Also, there is a fear that malpractice insurers will compel physicians and hospitals to use these agreements and thereby force health care providers to surrender their important right to vindicate their reputations before a jury.[228]

Although an act of the Maryland General Assembly would enhance the likelihood that a malpractice arbitration contract would be upheld by the courts, a common law framework already exists to support such a bargain.[229] As the Michigan statistics reveal, however, public misconceptions about the important rights being waived renders these agreements subject to attack under contract and public policy principles. Perhaps the doctor-patient relationship inherently precludes equal bargaining

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(1981), *rev'd*, 418 Mich. 423, 344 N.W.2d 736 (1984); Morris v. Metriyakool, 107 Mich. App. 100, 309 N.W.2d 910 (1981), *aff'd*, 418 Mich. 423, 344 N.W.2d 736 (1984); Brown v. Siang, 107 Mich. App. 91, 309 N.W.2d 575 (1981).

222. *See* MD. R.P. 4-246; *see also* Epps v. State, 52 Md. App. 308, 450 A.2d 913 (1982) (waiver must be knowingly and intelligently entered).

223. The study was conducted by a commission appointed by the Michigan State Legislature. The statistics were compiled by an accounting firm. The results are reproduced in Mengel, *supra* note 216, at 335-37.

224. *Id.* at 336.

225. *Id.* at 337.

226. Seidel, *Malpractice Reform in Michigan*, 1976 DET. C.L. REV. 235, 249.

227. *See, e.g.*, ALASKA STAT. § 09.55.535(c) (1983) (30 days); MICH. COMP. LAWS ANN. § 600.5041(3) (West Supp. 1984) (60 days).

228. Seidel, *supra* note 226, at 249.

229. SPECIAL COMMITTEE, *supra* note 6, at 7; McGuirk & Rafferty, *supra* note 26, at 16. *See generally* 5A PERSONAL INJURY, *supra* note 17, ¶4.11 (discussing how arbitration agreement can be upheld without statutory authority).

power. In addition, it is conceivable that the suspect nature of these agreements would produce many court cases as parties seek to litigate the legal issue of enforceability.[230] Thus, much of the litigation that was supposed to be avoided would return in the form of allegations of overreaching. In this litigation, the elusive concept of unconscionability would be at issue rather than the already complicated issue of malpractice.

H. Abandon Arbitration?

Finally, several recent studies have recommended that health claims arbitration be abolished.[231] These critics reason that the process is simply too time consuming and too troublesome to salvage. To them, it is better to live with the shortcomings of the common law than to endure the delay and duplication spawned by arbitration. In the words of the Liebmann Commission, a "[s]econd rate procedure is not acceptable."[232]

What these critics have forgotten, however, is that the common law system was also unable to provide equitable claim resolution.[233] Rather than the fifteen months consumed by arbitration, court cases dragged on for years.[234] Moreover, according to recent estimates by the Maryland Administrative Office of the Courts, turning large numbers of malpractice suits over to the courts would further add to the delay.[235]

More importantly, at common law, medical malpractice was tremendously expensive. As trials and discovery dragged on year after year, the price tag rose to unprecedented heights. This rise in costs had two undesirable results. First, it became apparent that the patients were recovering only small portions of the verdicts in their favor, as litigation expenses and attorneys' fees consumed much of the awards.[236] Second, higher costs were passed on to the patient in the form of an increase in the cost of health care.[237] These cost increases were equally troubling;

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230. Mengel, *supra* note 216, at 331.

231. *See supra* note 156. There are several bills pending before the Maryland General Assembly that would accomplish this end, including Senate Bills 152, 153, 154, and 155.

232. LIEBMANN REPORT, *supra* note 11, at 12.

233. *See supra* notes 2-40 and accompanying text.

234. Weston, *supra* note 133, at 6.

235. Memorandum from Peter J. Lally to James H. Norris (Feb. 27, 1984) (fiscal impact upon the courts if the Arbitration Office is abolished); *see also* ARBITRATION OFFICE STUDY, *supra* note 70, at 45-47 (explaining the added burden abolition would place on the circuit courts if nearly 1000 malpractice cases were added to the dockets).

236. The estimates on the amount of the award reaching the patient slip as low as seventeen percent. SPECIAL COMMITTEE, *supra* note 6, at 2.

237. According to the Prince George's Medical Society, the cost of inflated malpractice premiums added $35.00 per day to the cost of a hospital room. Statement of Leon R. Levitsky, M.D., Past President, Prince George's Medical Society Executive Committee, Prince George's County Medical Society (Feb. 25, 1976) (available in Maryland Legislative Reference File HB986). The Liebmann Report, however, contradicts these findings. LIEBMANN REPORT, *supra* note 11, at 2-9.

the system which provided only limited compensation for injured patients was being financed by the very patients it sought to protect.

VII. A MODEST PROPOSAL[238]

As the preceding analysis has revealed, there are a number of problems with the current health claims arbitration system. This is not to imply that the system is beyond salvation. Rather, a careful appraisal of the problems created by medical malpractice in general, coupled with a recognition of the limitations imposed on the finality of the arbitrators' decisions, lead to the conclusion that a streamlined health claims arbitration procedure is needed.

First, well-trained and well-selected arbitrators are essential if panels are to reach correct decisions. A warm body in the arbitrator's seat serves no purpose unless it can make the meaningful contribution it was placed there to accomplish. Thus, only medical and legal specialists, competent to handle the particular problems presented by a particular kind of malpractice case, should be selected as arbitrators. Selection of arbitrators should, therefore, be made case by case, matching the personnel to the issues. Demanding, however, that these medical and legal specialists serve on panels without compensation is as unwise as it is unrealistic. Instead of involuntary service, the professionals on the panel must be offered an incentive to serve and given the confidence that theirs will be a meaningful contribution to the result of the case. The lay panel member, by contrast, is the perfect subject for a generalized compulsory selection process. Rather than expertise or knowledge, all he brings to the panel is a conscience and a willingness to search for the truth. Other motives are unacceptable.

Second, if an arbitration system is to function efficiently, it must provide a swift ruling on the merits of a claim. There are a number of ways in which this might be accomplished. In Arizona, the legislature has set an eight-hour limit on the duration of an arbitration hearing.[239] Although this is a step in the right direction, it fails to account for the time consumed in pre-hearing preparation, which is where most of the time is consumed. The Liebmann Report advocates a two expert limitation, unless the panel chairman finds good cause to permit additional experts.[240] Once again, this proposal is a step in the right direction, but it does not go far enough.

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238. This heading, borrowed from J. SWIFT, A MODEST PROPOSAL FOR PREVENTING THE CHILDREN OF POOR PEOPLE FROM BEING A BURTHEN TO THEIR PARENTS OR THE COUNTRY, AND FOR MAKING THEM BENEFICIAL TO THE PUBLICK (W. Bickerton 2d ed. 1730), has been chosen because, although this proposal is neither satirical nor extreme as was Swift's, the authors believe it is a substantial departure from any of the previously discussed proposed solutions.

239. ARIZ. REV. STAT. ANN. § 12-567(D) (Supp. 1984-1985).

240. LIEBMANN REPORT, *supra* note 11, at 30; *see also* ARBITRATION OFFICE STUDY, *supra* note 70, at 43 (quoting the Liebmann Report proposal approvingly).

What is needed is an abbreviated proceeding in which the panel, and not the parties, determines what evidence it will hear. Thus, under this inquisitorial system, only the depositions of the experts consulted by the parties would be submitted, unless the panel wanted to hear the live testimony of any witness.[241] This would put the panel in control of what it needed to hear to decide the case, while reducing the length of most hearings considerably.

Given the abbreviated nature of this proceeding, it would be reasonable to require that third party claims against nonhealth care providers be arbitrated. To exempt nonhealth care providers from arbitration would result in the filing of two lawsuits to resolve what is essentially one issue of fact. Not only is this unjustifiably wasteful, but the separate factfinders might reach different conclusions. This is especially likely because of the relaxed rules of evidence in the arbitration setting.

Some report writers proposed to solve the third party problem by requiring that malpractice cases to which nonhealth care providers are joined be immediately transferred to the circuit court for trial of the entire case.[242] There are several problems with creating such an exemption from health claims arbitration. First, as the reports concede, there is the probability that anyone wishing to avoid arbitration would simply join a nonhealth care provider.[243] Although the reports caution that such abuse could be reduced by requiring arbitration of all cases in which the nonhealth care provider was dismissed from the case in circuit court,[244] they suggest no remedy for the delay resulting from shuttling the case from arbitration to circuit court and back again to arbitration. Second, because the health care provider on the arbitration panel is likely to be familiar with the medical products involved, there is no reason to exempt these cases from arbitration. In addition, exemption of nonhealth care providers from arbitration would defeat one of the central objectives of the arbitration system: keeping complicated malpractice cases out of the circuit court. Thus, it makes more sense to resolve all the disputes in one case before the arbitration panel.

Once all the evidence was in the record, the panel would begin its deliberative process. One of three results would be produced by these deliberations: 1) a finding that the health care provider was negligent; 2) a finding of non-liability; or 3) a finding that it was impossible, without a complete trial, to decide the issue. If the panel found evidence of negligence, it would set a damage award based upon the plaintiff's actual present and future economic losses and any pain and suffering. Some

241. The Maryland State Bar Association initially recommended a similar arbitration system. *See* SPECIAL COMMITTEE, *supra* note 6, at 3-4. The reason for the abbreviated hearing was "to insure that the hearing would not be transformed into a replica of a full scale trial." *Id.*

242. ARBITRATION OFFICE STUDY, *supra* note 70, at 42-43; MSBA, *supra* note 156, at 137-38.

243. See *supra* note 242.

244. See *supra* note 241.

states have prohibited awards for pain and suffering under the guise of reducing awards.[245] Leaving aside the potential constitutional infirmities of these statutes,[246] there is no valid reason for singling out malpractice cases. Thus, pain and suffering should remain an element of damages. Lastly, any award would include the costs of arbitration.

At this juncture, the panel would present its findings to the parties. They would be free to accept the findings or to pursue an action to nullify in the circuit court. If an action to nullify is filed by the party who prevailed before the panel, the panel award would be vacated.[247] Hence, no mention of it could be made in court. This would prevent plaintiffs from using the panel award as a floor from which to argue for additional damages. Those plaintiffs who prevail before the panel and fail to secure an equal or greater award in circuit court would have to pay the other party's expenses. These expenses would include the opponent's attorney's fees.[248] This sanction would surely dampen the filing of knee-jerk appeals. If nothing else, it would place the costs of filing such appeals on the one who ought to pay them.

For those physicians who lose before the panel, an action to nullify could be taken without penalty. But if the panel decision is affirmed or not reduced, interest on the award would run from the date the panel's decision was returned and the appellant would be assessed costs and expenses. As above, the expenses should include the appellee's attorney's fees.

The deference accorded the panel's decision would remain the same as under the present system.[249] According to *Attorney General v. Johnson*,[250] this is an inescapable constitutional requirement.[251] The trial in the circuit court would remain unchanged. At the request of the party who prevailed before the panel, however, the health care provider from the panel could be called as an expert to explain to the jury why the panel found as it did. Of course, the party calling the health care provider panel member as an expert would have to bear the expense of compensating the expert. This would guarantee that the basis for the panel decision was adequately explained, while providing the appellee with an available expert who is already familiar with the case.

This system of arbitration represents a realistic appraisal of the limitations imposed by *de novo* review. Under its operation, discovery would be shortened as would be the arbitration hearing process. As a result, all

245. *See, e.g.*, IND. CODE ANN. § 16-9.5-2-2 (Burns 1983); VA. STAT. § 8.01-581.15 (1984). *See generally* J. KALISCH, MEDICAL MALPRACTICE ¶ 20.07 n.59 (Supp. 1983) (citing to D. LOUISELL & H. WILLIAMS, *supra* note 15).

246. *See generally* Taylor & Shields, *The Limitation on Recovery in Medical Negligence Cases in Virginia*, 16 U. RICH. L. REV. 799 (1982).

247. For a comparable proposal, see SPECIAL COMMITTEE, *supra* note 6, at 5.

248. *Id.* at 5-6.

249. *See supra* notes 108-27 and accompanying text.

250. 282 Md. 274, 385 A.2d 57, *appeal dismissed*, 439 U.S. 805 (1978).

251. *Id.*

parties concerned would have swifter access to justice and the cost of litigation would be reduced substantially. The presumption of correctness, when coupled with monetary sanctions for meritless appeals, would produce some incentive to settle. If nothing else, monetary sanctions would impose the costs of delay upon the person who caused it: the appealing party.

VIII. CONCLUSION

With malpractice suits and awards on the rise, the Maryland General Assembly is again confronted with a malpractice crisis, one having new dimensions. What distinguishes this crisis from its predecessor is that one of the major contributing factors to the current crisis is the arbitration system created by the General Assembly in an effort to solve the former crisis. Another difference is that the legislature is now aware of the effect of the constitutional and practical limitations on the ability of arbitration to solve the problem. It is hoped that, benefitted by this insight, the General Assembly will set its sights on engineering a health claims arbitration system that is designed to cope with the problems outlined above. Only by the General Assembly's focusing upon these special considerations can any meaningful resolution of the crisis come about.