ANNUAL REPORT
OF THE
SPECIAL COMMISSION
Relative to
MEDICAL PROFESSIONAL LIABILITY
INSURANCE AND THE NATURE
AND CONSEQUENCES OF
MEDICAL MALPRACTICE
(Under section 12 of Chapter 362
of the Acts of 1975)

April 4, 1983
MEMBERS OF THE SPECIAL
COMMISSION ON MEDICAL
PROFESSIONAL LIABILITY INSURANCE

Sen. DANIEL J. FOLEY, Chairman
Rep. RAYMOND M. LaFONTAINE, Vice Chairman
Sen. ARTHUR J. LEWIS, Jr.
Rep. THEODORE J. ALEIXO, Jr.
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Mr. MICHAEL O’HARE
Mr. PATRICK CARROLL
Mr. RICHARD J. UNDERWOOD

STAFF TO THE SPECIAL COMMISSION

Edward J. Brennan, Jr., Esquire
Executive Director
E. Michael Paul Thomas
Research Director

LOCATION: Special Commission on Medical Professional Liability Insurance
Room 333, State House
Boston, Massachusetts 02133
(617) 722-1485
SPECIAL COMMISSION ON MEDICAL MALPRACTICE

SIGNATURES — ANNUAL REPORT 1981

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INTRODUCTION

The Special Commission on Medical Professional Liability Insurance was established pursuant to section 12 of Chapter 362 of the Acts of 1975.

Early in 1975, for reasons that are still uncertain, a crisis arose in Massachusetts medical professional liability insurance. Following the then-growing national trend, a major malpractice insurer announced its intention to withdraw abruptly from the Massachusetts market. Other carriers requested large rate increases or changes in underwriting policies from occurrence-based to claims-made policies. These developments threatened to make coverage unavailable or undesirable to many physicians in the Commonwealth. A serious threat to the Commonwealth's health care delivery system was inevitable unless strong legislative action was forthcoming. In June of 1975, the General Court responded and passed Chapter 362 of the Acts of 1975.

The most immediate objective of Chapter 362 was to guarantee the availability of medical malpractice insurance in the Commonwealth through the establishment of a Joint Underwriting Association (JUA). The enactment of the JUA was particularly timely since it was authorized days before the Commonwealth's major malpractice insurer was scheduled to leave the market. In its other sections, Chapter 362 was authorized direct control over the malpractice rating mechanism by requiring the Commissioner of Insurance to fix and establish medical malpractice insurance rates. The Chapter also provided for stricter controls on medical practice by establishing the Board of Registration in Medicine (formerly named the Board of Registration and Discipline in Medicine, changed by Chapter 58 of the Acts of 1979). It reformed the medical malpractice tort system by reducing the statute of limitations for minors, eliminating the ad damnum clause and requiring all medical malpractice cases to be screened by Medical Malpractice Tribunals within the Superior Court. Finally, section 12 of Chapter 362 established a Special Commission on Medical Malpractice to investigate and study the medical professional liability problem in Massachusetts to monitor the implementation of the entire Chapter.
The Joint Underwriting Association (JUA) was established as a temporary device in response to the impending withdrawal of all major private carriers of malpractice coverage from the Massachusetts market in 1975. The JUA was the major mechanism adopted by Chapter 362 of the Acts of 1975 to guarantee the continued availability of coverage at affordable premium charges. Chapter 751 of the Acts of 1981 extended the life of the Joint Underwriting Association (JUA) to December 31, 1983. Since its creation, the JUA has been virtually the sole provider of malpractice coverage for physicians, surgeons, and hospitals in the Commonwealth.

In 1979, the JUA provided malpractice coverage for an average of 9700 physicians and surgeons and for 124 hospitals throughout the state. In 1980, these figures were 9962 and 123, respectively. The number of claims filed against JUA insureds can be found in Table 1.

**TABLE 1.**

GENERAL AND PROFESSIONAL LIABILITY CLAIMS AGAINST JUA INSUREDs

<table>
<thead>
<tr>
<th></th>
<th>Physicians &amp; Surgeons</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975 (Six Months)</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>1976</td>
<td>118</td>
<td>207</td>
</tr>
<tr>
<td>1977</td>
<td>198</td>
<td>282</td>
</tr>
<tr>
<td>1978</td>
<td>295</td>
<td>272</td>
</tr>
<tr>
<td>1979</td>
<td>471</td>
<td>313</td>
</tr>
<tr>
<td>1980 (Eleven Months)</td>
<td>461</td>
<td>251</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1547</strong></td>
<td><strong>1341</strong></td>
</tr>
</tbody>
</table>
The outcomes of JUA cases in malpractice tribunal hearings are summarized in Table 2. In 1979, two hundred and sixty-seven JUA cases were heard by medical malpractice tribunals, of which 127 were decided for the plaintiff and 140 were decided for the defendant health care provider. Bonds were posted by the plaintiff in 44 of the 140 cases decided for the defendant health care provider. In eight months of 1980, tribunals heard 170 JUA cases, deciding 96, or 56 percent, for the plaintiff and 74, or 44 percent, for the defendant. Of the 74 cases, bonds were filed by the plaintiff in 25 cases. A total of 458 claims were closed by the JUA during 1979 and 475 claims were closed during 1980. In 1980, 157 of the closed claims were paid with indemnity while 318 were closed as unfounded.

### Table 2.

<table>
<thead>
<tr>
<th>Total Cases Heard</th>
<th>Findings For Plaintiff %</th>
<th>Findings For Defendant %</th>
<th>Bonds Posted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1977</td>
<td>58</td>
<td>30 (51.7)</td>
<td>28 (48.3)</td>
</tr>
<tr>
<td>1978</td>
<td>103</td>
<td>55 (53.4)</td>
<td>48 (46.6)</td>
</tr>
<tr>
<td>1979</td>
<td>267</td>
<td>127 (47.6)</td>
<td>140 (52.4)</td>
</tr>
<tr>
<td>1980 (eight months)</td>
<td>170</td>
<td>96 (56.5)</td>
<td>74 (43.5)</td>
</tr>
</tbody>
</table>

The JUA loss experience is presented, in approximate figures, in Table 3. In ten months of calendar year 1980, the JUA accumulated $24.8 million in Earned Premiums. Against these 1980 premiums, the JUA lists $22.0 million in Incurred Loss, $6.5 million in Loss Expense and $3.1 million in General Expense. The Incurred Loss and Loss Expense accounts are each comprised of three separate components. The Paid component contains the amounts actually paid in the Loss and Loss Expense (for 1980, $3,924,000 Loss and $961,000 Loss Expense): Case Reserves include the amounts reserved for future payments in Loss and Loss Expense for claims that have already been reported (for 1980, $13.631 million Loss and $2.7 million Loss Expense). Finally, claims that are expected to arise, according to
### TABLE 3.

**JUA EXPERIENCE SINCE JULY 1, 1975**

(Figures Are In Millions Of Dollars)

<table>
<thead>
<tr>
<th></th>
<th>Earned Premium</th>
<th>Loss Incurred</th>
<th>Loss Expense</th>
<th>Expense</th>
<th>Paid</th>
<th>Case Reserves</th>
<th>IBNR</th>
<th>Loss Expense</th>
<th>Paid</th>
<th>Reserves IBNR</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-75</td>
<td>4.8</td>
<td>2.5</td>
<td>1.2</td>
<td>2.3</td>
<td>.0005</td>
<td>.124</td>
<td>2.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-12-76</td>
<td>23.2</td>
<td>12.7</td>
<td>6.4</td>
<td>4.3</td>
<td>.023</td>
<td>2.002</td>
<td>10.6</td>
<td></td>
<td>.008</td>
<td>1.0</td>
</tr>
<tr>
<td>1-12-77</td>
<td>26.9</td>
<td>26.0</td>
<td>13.0</td>
<td>4.1</td>
<td>.373</td>
<td>4.465</td>
<td>21.2</td>
<td></td>
<td>.089</td>
<td>2.21</td>
</tr>
<tr>
<td>1-12-78</td>
<td>28.0</td>
<td>20.9</td>
<td>10.3</td>
<td>3.2</td>
<td>1.260</td>
<td>5.916</td>
<td>13.7</td>
<td></td>
<td>.183</td>
<td>2.94</td>
</tr>
<tr>
<td>1-12-79</td>
<td>25.0</td>
<td>24.2</td>
<td>11.1</td>
<td>2.9</td>
<td>2.897</td>
<td>14.748</td>
<td>6.5</td>
<td></td>
<td>.512</td>
<td>6.8</td>
</tr>
<tr>
<td>1-10-80</td>
<td>24.8</td>
<td>22.0</td>
<td>6.5</td>
<td>3.1</td>
<td>3.924</td>
<td>13.631</td>
<td>4.4</td>
<td></td>
<td>.961</td>
<td>2.7</td>
</tr>
<tr>
<td>TOTALS</td>
<td>132.7</td>
<td>108.3</td>
<td>48.5</td>
<td>19.9</td>
<td>8.4775</td>
<td>40.886</td>
<td>58.7</td>
<td></td>
<td>1.753</td>
<td>15.711</td>
</tr>
</tbody>
</table>
actuarial projections, but which have not yet been reported, are accounted in the Incurred But Not Reported (IBNR) reserves for Loss and Loss Expense (for 1980, $4.4 million Loss and $2.1 million Loss Expense).

Under Chapter 362, the Commissioner of Insurance is empowered to “fix and establish” premium levels to be charged by all malpractice insurers conducting business in the Commonwealth, including the JUA. Until 1978, the annual rate-setting hearings were forums for major debates among the many interested parties over rate-making methodologies, data bases, and actuarial techniques for estimating future losses and expenses for malpractice coverage. In 1978, the parties to the rate-setting hearings arrived at a rate structure that was presented to the hearings as a stipulation by all the parties. This stipulation was adopted by the Commissioner and promulgated in his decision fixing rates for 1979.

A similar procedure was used to facilitate the recent process for setting the 1980 rates. The parties to the 1980 proceedings included the JUA, the State Rating Bureau, the Massachusetts Medical Society, Hospital Association, Radiological Society, Society of Anesthesiologists, and the Massachusetts Chapter of the American Academy of Pediatrics. These parties collaborated in preparing a joint stipulation which was adopted in the Commissioner’s 1980 rate decision.

The 1980 rates, as stipulated by the parties and adopted by the Commissioner, imposed a 10 percent increase over 1979 rates for claims-made and occurrence coverage for physicians and surgeons. For hospital coverage, claims-made rates were decreased by 10 percent from the 1979 rates, while occurrence rates remained at the 1979 level. These figures amounted to an overall increase of 5.3 percent in the amount of premiums expected by the JUA during 1980.

Thus, the 1980 rates reflected a continued confidence that the medical malpractice insurance market has stabilized in Massachusetts. Since a freeze was imposed on all rates in 1975, only slight changes have been permitted in the rates. Despite protests at various times that the rates allowed by the Commissioner were inadequate, rebates were provided during 1979 to return excess premiums to some JUA insureds.

The 1981 rates for hospitals were also settled by a stipulation among the parties, who agreed to a 30 percent across the board reduction in
hospital premiums. However, the parties were unable to agree on 1981 rates for physicians and surgeons, with parties insisting on levels ranging from 10 to 55 percent increases over previous years' premiums. The Special Commission is very pleased with the moderation in rates that has predominated in recent years. The noncontentious manner in which rate decisions have been made reflects the general stability of the Massachusetts malpractice system. Once again we direct the attention of private insurers to this stability and encourage them to consider renewed involvement in the Massachusetts market.

**BOARD OF REGISTRATION IN MEDICINE**

The Board of Registration in Medicine continues to suffer from chronic staffing problems because of its organizational location within the Division of Registration and the Secretariat of Consumer Affairs. Despite the fact that the Board has been fully funded and authorized by the legislature in the past three budgets, the Board has experienced staffing shortages as high as fifty percent because of difficulties in securing the necessary approvals for new and replacement hiring. These shortages have severely undermined the Board’s efforts to assure the quality of medical care provided in the Commonwealth. As such, these difficulties pose a serious threat to the health and safety of our citizens.

In light of the lengthy tenure of these problems and the apparent ease with which a properly motivated administration would rectify them, the Special Commission has concluded that these difficulties must be attributed to an apparent lack of interest on the part of the Administration in providing sufficient staff for the Board of Registration in Medicine to function properly.

The staffing problems have had the greatest adverse impact on the Board’s disciplinary activities, which have been severely undermined by funding and staffing difficulties since the Board’s inception. As indicated by the Board’s Annual Report for 1979, dispositions of disciplinary activities declined from 23 Orders to Show Cause in 1978 to 10 in 1979. This reduction in effectiveness was attributed by the Board to the fact that the disciplinary activities were understaffed to the extent of three attorney positions for much of 1979. One of the staff deficiencies was due to the departure of an executive secretary who was
also serving as a prosecuting attorney. However, the other two positions had been either unfunded or unauthorized, and, as a result, unfilled, since the creation of the Board in 1976.

In 1980, the Board finally received funding and authorization sufficient to fully staff its disciplinary activities. The filling of these positions marked the first time that the Board achieved complete staffing. However, the Board's professional staff was complete for a very brief time, bringing the number of disciplinary actions up, somewhat, to 17 in 1980, but still below the 1978 level. The complete staffing of its disciplinary activities in 1980 assisted the Board in increasing the number of final disciplinary action to 17 for the year. The outcomes of these 17 cases are described in Table 4. During the Fiscal Year 1980, the Board received 246 complaints and docketed 139 of these for further inquiry, 80 of which are still pending. Orders to Show Cause were issued in 28 cases, and 107 complaints were referred to other agencies.

**TABLE 4.**

**FINAL OUTCOMES OF DISCIPLINARY ACTIONS, CALENDAR YEAR 1980**

- 5 licenses revoked
- 1 license suspended
- 1 reprimand
- 2 settlement agreements
- 4 reprimands and settlements agreements
- 4 dismissals
- 17 cases concluded

In the past two years, the Board’s registration activities suffered less from its staffing difficulties than did its disciplinary activities. In its 1979 Annual Report, the Board reported registering 14,647 physicians. In 1980, the number increased to 17,892. Fifty-three percent of the registrants reported board certification. Limited licenses were issued to 1935 physicians in 1979 and 1340 physicians in 1980. As part of the registration procedure in 1979, the Board also collected information on malpractice actions filed against registrants. This survey disclosed that 3.6% of the registered physicians (533 physicians) were
defendants during the two year registration period, indicating an incidence of 1.8 percent per year, or one malpractice suit for every 55 years of practice. In addition the Board reported that 486 physicians had their hospital privileges restricted during the 1979 survey period. In this survey, 29 physicians reported both occurrences — a malpractice suit and a privilege restriction — during the survey period.

In 1981, the staffing levels at the Board collapsed once again, to the point where it fell 50% below 1980 levels, signalling an end to the brief period of complete staffing in 1980. To a large extent, the Board’s staffing problems arise from the nature of its relationship with the Division of Registration, the parent agency for the twenty-seven Boards of Registration that regulate the professions licensed under Massachusetts law. The Division maintains a central staff which is loaned out to the various Boards to meet seasonal changes in workload. With the exception of its investigators and lawyers, all of the staff of the Board of Registration in Medicine is supplied in this fashion by the Division, as employees of the Division on assignment to the Board. As a result, the Division’s responsiveness to the Medicine Board’s requests for staff assistance at any given time may be adversely affected by circumstances prevailing at the other Boards at that time. In the past, this has caused the Medicine Board great difficulties in meeting deadlines, particularly if the Division is experiencing one of its periodic staffing problems. The major staffing problem still faced by the Board arises from the fact that several of the Board’s long-term staff members are nominally employees of the Division rather than the Board. The confusion created by this arrangement could be lessened by transferring these employees to the Board.

In the light of the great importance of the Medicine Board’s activities, the Special Commission is concerned that the Board be assured sufficient staff assistance. The first step toward correcting the Board’s staffing problems requires that the necessary personnel transfers be made to place all Board staff members wholly within the Board’s administrative structure. However, the Special Commission is no longer hopeful that these measures will rectify the Board’s problems entirely. As a result, the Special Commission will conduct research and hearings into the possibility and desirability of establishing the Board as a separate agency, outside the Division of Registration and, perhaps, outside the Secretariat of Consumer Affairs.
The malpractice tribunals were created by Chapter 362 of the Acts of 1975 as a mechanism to discourage the pursuit of frivolous medical malpractice claims. Under the terms of the Act, any claim for "malpractice, error or mistake against a provider of health care" must first be heard before a malpractice tribunal. At the tribunal hearing, the plaintiff must make "an offer of proof" that will be examined by the tribunal to "determine if the evidence if properly substantiated is sufficient to raise a legitimate question of liability appropriate for judicial inquiry or whether the plaintiff's case is merely an unfortunate medical result". General Laws Chapter 231, Section 60B. If the plaintiff fails to meet the tribunal's required offer of proof against one or more defendants, the plaintiff will then be required to post bond in order to pursue further legal action against those defendants.

As indicated by the statistics in Table 5 and the summary in Table 6, the tribunals have been very successful in screening malpractice cases out of the court system. The most recent complete figures, as of 8/1/78, show that more than half of the cases decided by the tribunals resulted in insufficient findings with respect to some or all of the defendants (45.4 percent insufficient and 9.2 percent split decisions). The percentage of cases in which bonds were filed has remained essentially constant at about 12.5 percent since the tribunals began operation. The most recent though incomplete figures, compiled as of August 30, 1980, indicate that a somewhat larger percentage of cases are receiving sufficient findings from the tribunals. However, inquiries made by the Tribunal Subcommittee of the Special Commission indicate that this increase is probably due to better preparation for tribunals and greater selectivity in cases brought before the tribunals by plaintiffs' attorneys, rather than any tendency toward relaxation of tribunal standards.

A number of recent court decisions have clarified the tribunal procedures. The case of McMahon v Glixman, Massachusetts Advance Sheets (1979) 2277, assumed that a plaintiff has a right to appeal legal errors allegedly made by malpractice tribunals in reaching insufficient findings. The Supreme Judicial Court held: "If a plaintiff elects to have the alleged legal errors reviewed on appeal without first filing a bond and going to trial, knowing that he thereby runs the risk of being out of court entirely if his claim of error by the tribunal is decided..."
TABLE 5.

DISPOSITION OF MEDICAL MALPRACTICE TRIBUNALS

(All Counties Are Not Reported)

<table>
<thead>
<tr>
<th>County</th>
<th># of Cases</th>
<th>Sufficient Finding</th>
<th>Not Sufficient Finding</th>
<th>Bond Filed</th>
<th>Split Decision</th>
<th>Tribunal Forthcoming</th>
<th>Dismissed Before Tribunal</th>
<th>No Hearing Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnstable</td>
<td>28</td>
<td>11</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Dukes</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Franklin</td>
<td>12</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hampshire</td>
<td>22</td>
<td>10</td>
<td>9</td>
<td>3</td>
<td>28</td>
<td>193</td>
<td>31</td>
<td>15</td>
</tr>
<tr>
<td>Middlesex</td>
<td>444</td>
<td>94</td>
<td>83</td>
<td>22</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nantucket</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>16</td>
<td>7</td>
<td>26</td>
<td>13</td>
</tr>
<tr>
<td>Norfolk</td>
<td>194</td>
<td>90</td>
<td>42</td>
<td>13</td>
<td>12</td>
<td>72</td>
<td>39</td>
<td>10</td>
</tr>
<tr>
<td>Suffolk</td>
<td>392</td>
<td>148</td>
<td>111</td>
<td>31</td>
<td>6</td>
<td>12</td>
<td>38</td>
<td>5</td>
</tr>
<tr>
<td>Worcester</td>
<td>169</td>
<td>69</td>
<td>39</td>
<td>18</td>
<td>66</td>
<td>289</td>
<td>140</td>
<td>47</td>
</tr>
<tr>
<td>TOTALS</td>
<td>1269</td>
<td>431</td>
<td>296</td>
<td>92</td>
<td>66</td>
<td>289</td>
<td>140</td>
<td>47</td>
</tr>
</tbody>
</table>

(As of June 30, 1980)
TABLE 6.

SUMMARY OF TRIBUNAL OUTCOMES

<table>
<thead>
<tr>
<th></th>
<th>As of 7/11/77</th>
<th>As of 8/1/78</th>
<th>As of 6/30/80 (Incomplete)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
</tr>
<tr>
<td>Total Tribunal Decisions Issued</td>
<td>241</td>
<td>575</td>
<td>793</td>
</tr>
<tr>
<td>Sufficient Findings</td>
<td>101 (41.9)</td>
<td>261 (45.4)</td>
<td>431 (54.4)</td>
</tr>
<tr>
<td>Insufficient Findings</td>
<td>119 (49.4)</td>
<td>261 (45.4)</td>
<td>296 (37.3)</td>
</tr>
<tr>
<td>Split Decision (Bond Required For Proceeding Against Some Defendants)</td>
<td>21 (8.7)</td>
<td>53 (9.2)</td>
<td>66 (8.3)</td>
</tr>
<tr>
<td>Cases In Which Bond Was Filed</td>
<td>29 (12.0)</td>
<td>72 (12.5)</td>
<td>92 (11.6)</td>
</tr>
</tbody>
</table>

adversely to him, we believe that he is entitled to review. On the other hand, he may instead file his bond, go to trial, and, if he loses, have the alleged error by the tribunal reviewed along with any other alleged errors arising from the trial. It is for him to decide whether he is willing to assume the potentially fatal risks of pretrial review after failing or refusing to file a bond.”

In the case of Little v Rosenthal, Massachusetts Advance Sheets (1978) 2793, the Supreme Judicial Court clarified the standard of review that must be applied by tribunals in evaluating the plaintiff’s “offer of proof”. The court ruled that the tribunal must examine the
plaintiff's evidence in a manner analogous to “the trial judge's function” in ruling on a defendant’s motion for direct verdict. Thus the tribunal must examine the offer of proof in the light most favorable to the plaintiff and may not attempt to appraise the weight and credibility of the evidence offered by the plaintiff.

Relying on these cases, the Supreme Judicial Court, in Kapp v Ballantine, Massachusetts Advance Sheets (1980) 755, rules that tribunals “should give consideration to the proffered opinion of an expert if the offer of proof (concerning the expert’s qualifications) is sufficient to show that a trial judge in his discretion might properly rule that the qualifications of the witness are sufficient.” This ruling substantially limits the tribunals’ authority to reject expert testimony presented by apparently qualified plaintiffs’ experts. The Court also ruled that the tribunal must allow the plaintiff to go forward if the offer of proof is sufficient as to any one of the plaintiff’s various theories.

In the case of Franklin v Albert, Massachusetts Advance Sheets (1980), the Supreme Judicial Court reconsidered longstanding doctrines under the statute of limitations that specified when a cause of action for medical malpractice accrues. The prevailing doctrine, dating from the case of Capucci v Barone, 266 Mass. 578 (1929), dictated that the cause of action accrues at the time of the act of malpractice, “and not when the actual damage results or is ascertained.” Thus, under the Capucci standard, the statute of limitations would toll when the act of malpractice occurred and would expire three years after the occurrence of the act, whether or not damage resulting from the act has resulted or has been discovered by the plaintiff prior to the expiration date. In Franklin v Albert, the Supreme Judicial Court overruled this doctrine, articulated in Capucci and in the later case of Pasquale v Chandler, 350 Mass. 450 (1966), and held that “a cause of action for medical malpractice does not ‘accrue’ under General Laws, Chapter 260, Section 4, until a patient learns, or reasonably should have learned, that he has been harmed as a result of a defendant’s conduct.” The Court concluded that the Pasquale decision had been based on an unwarranted interpretation of legislative activity concerning the malpractice statute of limitations. Moreover, the Court found that the Capucci and Pasquale doctrines did not comport with the valid policy objectives of statutes of limitations to “promote repose by giving security and
stability to human affairs” and to “encourage plaintiffs to bring actions within prescribed deadlines when evidence is fresh and available.” The Court observed that “the manifest injustice of the Capucci doctrine is that, rather than punishing negligent delay by the plaintiff, it punishes ‘blameless ignorance’ by holding a medical malpractice action time-barred before the plaintiff reasonably could know of the harm he has suffered.” In applying the discovery rule to medical malpractice actions, the court noted that other states with similar rules imposed an outer limit in which an action must be brought, but left this question open for consideration by the Legislature.

In the case of Gugino v Harvard Community Health Plan, Massachusetts Advance Sheets (1980) 1037, the Supreme Judicial Court applied the standards of Kapp v Ballantine to require that “the plaintiff present, not mere allegations or an oral offer of proof by counsel, but ‘evidence’ to be ‘properly substantiated’ at trial. The witnesses need not testify in person, and allowance should be made for the fact that the hearing before the tribunal ordinarily precedes discovery. In particular, inadequacies in defendants’ records should not disadvantage the plaintiff”.

In light of these judicial decisions, the Tribunal Subcommittee of the Special Commission has conducted an examination of the procedures of the malpractice tribunals, resulting in three recommended alterations of existing procedures. First, the Special Commission recommends that opportunity should be given for limited discovery proceedings prior to the tribunal hearings. The tribunals are intended to screen out frivolous or insubstantial cases, but the absence of discovery mechanisms prior to the tribunals may result in eliminating proper cases only because the plaintiff is denied access to information under the defendant’s control. The Special Commission recommends that discovery mechanisms be made available to the plaintiff, upon motion and approval by the Court, if the plaintiff can demonstrate that the information is necessary for preparation of the offer of proof for the tribunal hearing.

Second, the Special Commission recommends that the statutory timetable for the tribunals be amended to require that tribunal hearings be held within sixty days after the defendant’s answer has been filed. The present provision requiring a hearing within fifteen days has
been proven impractical given the large number of tribunal cases and the length of time required to convene each tribunal.

Third, the Special Commission recommends that the testimony at tribunals and the findings of tribunals should be inadmissible in subsequent judicial proceedings. The Tribunal Subcommittee found a wide consensus with the judiciary, the plaintiffs' bar and the defendants' bar that the current admissibility of tribunal testimony and findings raises substantial questions about the equity and due process of tribunal proceedings. The initial justification for allowing this information to be admissible was to enhance the effectiveness of the tribunals in deterring frivolous suits. It is now clear that the tribunals have a substantial deterrent effect, largely as a result of the bond requirements. In order to avert any possible constitutional challenge based on this issue, the Special Commission recommends that Chapter 362 be amended to render tribunal testimony and findings inadmissible in subsequent court proceedings.

Finally, the Special Commission is aware that the decision in Franklin v. Albert, has caused some anxiety about possible increases in malpractice actions resulting from the expanded statute of limitations under the “discovery rule” applied by that case. At present, the Special Commission possesses no information suggesting that such an increase has occurred or will occur. However, the Special Commission will monitor the incidence of malpractice actions to determine if this decision has had an undesirable effect on the malpractice system.

CONCLUSION AND SUMMARY OF RECOMMENDATIONS

In contrast to statements of alarm issuing from other parts of the country, the malpractice crisis of 1975 shows no signs of awakening in Massachusetts at the present time. Malpractice insurance premiums remain at a very reasonable level in Massachusetts compared to other states. No signs of increased claims incidence and few signs of increased claims severity have been observed. Apart from chronic staffing aggravations, the Board of Registration in Medicine is fully operational and pursuing its dual objectives of registration and discipline of the Commonwealth's physicians. Finally, the malpractice tribunal system has withstood all court challenges to its validity.
Through a series of judicial decisions a set of procedures has been developed for the tribunals that corresponds very closely with the initial objectives of the 1975 Malpractice Reform Act.

To continue the smooth and effective operation of the 1975 legislation, this Report contains four specific recommendations:

(1) To ease the personnel difficulties of the Board of Registration in Medicine, all employees of the Board should be formally removed from the administrative structure of the Division of Registration and placed instead within the Board's own administration.

(2) To guarantee access to the information necessary for the preparation of the plaintiff's offer of proof for medical malpractice tribunals, limited discovery procedures should be available prior to tribunal hearings, upon motion and approval by the Court.

(3) To reflect the practical demands of administering the tribunal system, the present provision requiring that a hearing be held within 15 days of the filing date of the defendant's answer should be changed to allow 60 days between the answer and the tribunal hearing.

(4) To eliminate lingering doubts about the due process afforded by the tribunal hearings, testimony at tribunal hearings and the findings of the tribunal should be inadmissible in subsequent judicial proceedings.
AN ACT CLARIFYING THE PROCEDURES GOVERNING THE MEDICAL MALPRACTICE TRIBUNALS.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 60B of Chapter 231 of the General Laws, as inserted by section 5 of Chapter 362 of the Acts of 1975, is hereby amended by striking out in the fifth paragraph the first sentence and inserting in place thereof the following sentence: — Every such action for malpractice shall be heard by said tribunal within sixty days after the defendant's answer has been filed.

SECTION 2. Section 60B is further amended by striking out in the fifth paragraph the last sentence and inserting in place thereof the following sentence: — The testimony of said witness and the decision of the tribunal shall not be admissible as evidence at a trial.

SECTION 3. Section 60B is further amended by inserting after the fifth paragraph thereof, the following paragraph: — The court on motion, and for good cause shown, may allow discovery, as governed by the rules of civil procedure, prior to a tribunal hearing.