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)

June 12, 1979
SPECIAL COMMISSION ON MEDICAL MALPRACTICE SIGNATURES — ANNUAL REPORT, 1978

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SEN. ARTHUR J. LEWIS, JR.
SEN. JOHN F. AYLMER
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DR. RICHARD F. GIBBS
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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 a then-growing national trend, a major malpractice insurer announced its intention to withdraw abruptly from the Massachusetts market, and 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 authorizes direct control over the malpractice rating mechanism by requiring the Commissioner of Insurance to fix and establish medical malpractice insurance rates. The Chapter also provides for stricter controls on medical practice with the establishment of the new 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 reforms 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 establishes a Special Commission on Medical Malpractice to investigate and study the medical professional liability problem in Massachusetts and to monitor the implementation of the entire Chapter.
More than three years have elapsed since the passage of Chapter 362 during which time the Special Commission has been monitoring the effectiveness of its provisions in remedying the symptoms of the 1975 crisis. In general, the conditions which contributed to the crisis atmosphere in Massachusetts at the time have largely subsided, partially through their own momentum and partially as a result of the Chapter 362 reforms. In previous Annual Reports, the Special Commission has attempted to address the "causes" of the crisis, to document its severity and extent, and to assess the effectiveness of the Chapter 362 provisions. In light of the stability that has prevailed of late in the Massachusetts malpractice market, the Special Commission has focussed its attentions during the past year on an examination of the medium-term effectiveness of the reform measures instituted under Chapter 362. The results of this examination are contained in the following pages, together with recommendations for remedial measures to be taken to improve the fairness and effectiveness of the malpractice system in Massachusetts.
1979] HOUSE — No. 6534

JOINT UNDERWRITING ASSOCIATION

At the end of 1978, the Massachusetts Medical Malpractice Joint Underwriting Association (JUA) retained its status as virtually the sole provider of coverage for physicians, surgeons and hospitals in the Commonwealth. 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. It was established as a temporary device in response to the impending withdrawal of the major private carriers of malpractice coverage from the Massachusetts market in 1975. The JUA's members include all casualty insurance companies transacting business in Massachusetts.

An important part of Chapter 362 is a provision requiring the Commissioner of Insurance to "fix and establish" premium levels to be charged by all medical malpractice insurers doing business in the Commonwealth, including the JUA. This provision is commonly cited by private insurers as a major reason for their reluctance to resume business in Massachusetts. The annual rate-setting hearings held by the Commissioner of Insurance have, in previous years, been the occasion for wide-ranging discussions and disputes over rate making methodologies and actuarial techniques for estimating future losses and expenses on malpractice coverage. These hearings generally included at least three significantly different actuarial proposals, sponsored by representatives of the JUA, the medical profession and the Insurance Commissioner, each resulting in vastly different recommendations for the rates to be adopted. Beginning with a freeze on rates in 1975, the successive rate decisions by the Commissioner have provided for very slight changes, both increases and decreases. The resultant rates have been consistently described as inadequate by the actuaries for the JUA, who have projected deficits as large as fifty percent of the total volume of premiums.

The process for determining the 1979 medical malpractice rates differed strikingly from those of the preceding four years. This fall, virtually all of the previous points of contention were resolved in a prehearing stipulation among the parties to the rate making process, including the Massachusetts Medical Society, the Massachusetts
Society of Internal Medicine, Massachusetts Society of Anesthesiologists, Massachusetts Radiological Society, Massachusetts Chapter of the American Academy of Pediatrics, Massachusetts Hospital Association, the JUA and the State Rating Bureau of the Division of Insurance. This stipulation was presented at the formal rate setting hearing and was accepted by the Hearing Officer to be used as the 1979 rates.

The rates adopted for 1979 make moderate changes in the 1978 rates totalling a six per cent overall reduction in the JUA's 1978 total premium volume. Rates for occurrence-based coverage were continued at the 1978 level for physicians and surgeons and were reduced five per cent from 1978 for hospitals. Rates for the first four years of claims-made coverage were reduced ten per cent for physicians and surgeons and fifteen per cent for hospitals. A comparison of the 1978 and 1979 rates is given in Appendix A.

The moderate rate reductions for 1979 reflect the recognition that Massachusetts claims and loss experience has stabilized from the erratic situation which prevailed in the early 1970s. Moreover the 1979 decision includes provisions for substantial rebates to be paid to policyholders who purchased claims-made coverage from the JUA during the 1975 to 1977 period. The rebates amount to a 33.3 per cent refund to physicians and surgeons for first-year claims-made coverage and an 11.1 per cent refund for second-year claims-made coverage during that period. Hospitals with policies during the affected period will receive a 25 per cent first-year refund and a 15 per cent second-year refund.

In the view of the Special Commission, this year's rate setting process represents a convincing confirmation that the widespread dislocations in the Massachusetts medical malpractice insurance market prior to 1975 have been reversed. The premium refunds ordered by the 1979 rate decision are supported by the data presented in the Special Commission's 1977 Annual Report which indicated a reversal in 1975 of the rising trend in claims frequency that prevailed in Massachusetts over the years 1971 to 1974. It is particularly encouraging that the JUA was a party to the stipulation preceding this year's rate decision. We hope that the JUA's changed perception of the insurance climate in Massachusetts medical malpractice will be shared...
by private insurers who may be considering reentry into the market. However, until private insurers indicate a willingness to reenter the market, it is clear that the JUA must remain in operation.

Recommendation: The Special Commission recommends that the Joint Underwriting Association be extended until December 31, 1981.

In 1978, the JUA provided malpractice coverage for an average of 9,840 and 125 hospitals throughout the state. The number of medical malpractice claims filed against insureds of the JUA is given in Table 1. In 1978, the JUA closed a total of 372 claims. One hundred and three JUA cases were heard by medical malpractice tribunals of which 55 were decided for the plaintiff and 48 were decided for the defendant health care provider. Bonds were posted by the plaintiffs in eight of the 48 cases decided for the defendant health care provider.

MEDICAL MALPRACTICE

Table 1. 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>TOTAL</td>
<td>315</td>
<td>777</td>
</tr>
</tbody>
</table>

Approximate figures describing the JUA loss experience for its three and one-half years of operation are given in Table 2. For the first 10 months of 1978, the JUA accumulated $23.7 million in Earned Premiums. Against these 1978 premiums, the JUA lists $17.6 million in Incurred Loss, $8.6 million in Loss Expense and $2.7 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 Loss and Loss Expense (for 1978,
Table 2. JUA Experience Since July 1, 1975.
Figures Are In Millions of Dollars

<table>
<thead>
<tr>
<th></th>
<th>Loss Case</th>
<th>IBNR</th>
<th>Paid</th>
<th>Case Reserves</th>
<th>IBNR</th>
<th>Loss Expense</th>
<th>Case Reserves</th>
<th>IBNR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thru 12/31/75</td>
<td>4.8</td>
<td>1.2</td>
<td>2.3</td>
<td>.0005</td>
<td>.124</td>
<td>2.3</td>
<td>—</td>
<td>.061</td>
</tr>
<tr>
<td>1/1 -- 12/31/76</td>
<td>23.2</td>
<td>6.4</td>
<td>4.3</td>
<td>.023</td>
<td>2.002</td>
<td>10.6</td>
<td>.008</td>
<td>2.012</td>
</tr>
<tr>
<td>1/1 -- 12/31/77</td>
<td>26.9</td>
<td>13.0</td>
<td>4.1</td>
<td>.373</td>
<td>4.465</td>
<td>21.2</td>
<td>.089</td>
<td>2.21</td>
</tr>
<tr>
<td>1/1 -- 10/31/78</td>
<td>23.7</td>
<td>8.6</td>
<td>2.7</td>
<td>1.112</td>
<td>3.395</td>
<td>13.1</td>
<td>.139</td>
<td>1.69</td>
</tr>
<tr>
<td>TOTALS</td>
<td>78.6</td>
<td>29.2</td>
<td>13.4</td>
<td>1.5085</td>
<td>9.986</td>
<td>47.2</td>
<td>.236</td>
<td>4.961</td>
</tr>
</tbody>
</table>

Total Loss = 70.3
Plus Loss Expense = 70.3
Excluding IBNR = 16.7

Total IBNR = 16.7
Loss Plus IBNR = 70.3
Loss Expense = 70.3
$1,112,000 Loss and $139,000 Loss Expense). Case Reserves include the amounts reserved for future payments in Loss and Loss Expense for claims that have already been reported (for 1978, $3.395 million Loss and $1.69 million Loss Expense). Finally, claims that are expected to arise, according to 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 1978, $13.1 million Loss and $6.4 million Loss Expense). Estimation of the IBNR requires a projection of the total number of claims expected against a policy year and an estimate of the losses and expenses for each outstanding claim. The IBNR figures for 1978 are significantly lower than the corresponding 1977 figures. This reduction can be interpreted as a reflection in the JUA’s actuarial calculations of the growing awareness that the trends of increasing claims incidence and severity have been reversed.
RELATED LEGISLATION

The Massachusetts Supreme Judicial Court, in the case of Whitney v. City of Worcester, 366 N.E. 2d 1219 (1977), issued a ruling giving the Legislature until the end of the 1978 legislative session to repeal the doctrine of sovereign immunity and replace it with a coherent policy identifying the liability of governmental units and employees. The ruling went on to state that if the Legislature failed to adopt such a policy, the court would overturn the sovereign immunity doctrine retroactive to May, 1973. This action would have resulted in a sudden substantial increase in liability exposure to governmental facilities such as hospitals and clinics.

On July 20, Chapter 512 of the Acts of 1978 was approved in response to the SJC ruling. Chapter 512 essentially revoked the common law sovereign immunity doctrine and replaced it with a system of liabilities for governmental units and indemnities for their employees.

Under Chapter 512, public employers are liable for injury or loss of property or personal injury or death caused by the negligent or wrongful act or omission of any employee acting within the scope of his employment. This liability will accrue in the same manner and to the same extent as a private individual under like circumstances. However, by contrast with private individuals, the public employers will not be subject to levy of execution on any real and personal property to satisfy judgment against them. Also, public entities will not be liable for interest prior to judgment or for punitive damages or for any amount in excess of one hundred thousand dollars. Public employers are bound to provide reasonable cooperation to the public employer in the defense of any action brought under this chapter. An uncooperative employee may be held to be jointly liable with the public employer.

Chapter 512 allows public entities to purchase appropriate insurance to protect against judgments that might arise under the legislation. It also provides that public employers may indemnify public employees from financial loss and expenses, including legal fees and costs, if any, in an amount not to exceed one million dollars arising out of any claim action, award, compromise, settlement or judgment by reason of an intentional tort. This provision is only applicable if such
employee or official at the time of such intentional tort or such act or omission was acting within the scope of his official duties or employment.

During the past year legislation was sponsored by the Massachusetts Bar Association to provide for the creation of a Joint Underwriting Association and an Insurance Placement Facility for legal professional liability insurance. This legislation reflects concerns in other professions that developments might arise paralleling the medical malpractice crisis and threaten disruption of their activities. Although the legislation received a favorable report from the Insurance committee, no final action was taken on it by the entire legislature.

Much of the concern underlying the Bar Association's proposal arises from the small number of insurers offering legal malpractice insurance in Massachusetts. Currently there are as few as three commercial carriers providing coverage. The average premium is $550 for $100,000/$300,000 coverage, on a claims-made basis. Because of the thin state of the market, the sudden withdrawal of a carrier could cause problems in maintaining adequate availability of coverage.

The legislation proposed by the Bar Association allows the Commissioner of Insurance, at his discretion or upon petition by the Association, to hold hearings and make a determination of whether adequate professional liability coverage is available to the legal profession in Massachusetts. If the Commissioner finds that coverage is unavailable in adequate amounts, he must then establish a Legal Professional Liability Insurance Placement Facility and a Joint Underwriting Association. The Placement Facility would attempt to find an insurer for lawyers who have been refused coverage by other insurers, while the Joint Underwriting Association, thus, would function as a high-risk pool for legal malpractice insurance, with premium levels fixed by the Commissioner.

This legislation has been refiled for the 1979 legislative session.
BOARD OF REGISTRATION IN MEDICINE

The Special Commission is pleased to report that the physician registration activities of the Board of Registration in Medicine have effectively stabilized after the recurring budgetary and personnel shortages of past years. Registration of limited license physicians proceeded smoothly this year without the need for clerical assistance from the Division of Registration, resulting in the issuance of limited licenses before the July 1 deadline. The issuance and renewal of permanent licenses has also become routinized. At present there are 16,480 fully licensed physicians and 3,000 physicians with limited licenses in the Commonwealth. A summary of a management survey of the Board's operations performed by the Comptroller's Office is contained in Appendix B.

The disciplinary activities of the Board, however, are still being hampered by long-term uncertainties in staffing and funding levels. These activities are currently understaffed by one investigator and two lawyers because of inadequate funding. A narrative of the Board's funding history is found in Appendix C. The Board currently has only one investigator and one part-time attorney on its staff. In the absence of adequate disciplinary staff, the Board maintains a substantial portion of their cases in the "pending" stage, causing unnecessary delays in their investigation and disposition.

The importance of maintaining adequate funding and staffing for the Board's disciplinary activities is particularly acute in the prosecution of large or complex cases. Partly as a result of the general budgetary problems described above and partly because of uncertainties during the past year's budgetary proceedings concerning a proposal to consolidate the Division of Registration, the Board was unable to obtain funding necessary for pursuit of the so-called Malden Hospital case. In this case, a group of surgeons are under investigation for apparently substandard open-heart surgery practices that resulted in a substantially higher-than-expected mortality rate for their operations. This is an extraordinarily complex case, promising to have broad significance in future assessments of medical competence. It is also a very expensive case to pursue, far outstripping the present disciplinary
budget of the Board, thus requiring the Board to request supplemental funding from the Secretary of Consumer Affairs. In the absence of this funding, the Board's ability to pursue this very important case will be severely impaired.

*Recommendation:* The successful functioning of the Board's disciplinary activities is essential to maintaining quality health care in the Commonwealth. The Special Commission recommends that the Board be funded at a level sufficient to investigate and prosecute complaints promptly and completely.

A description of the Board's disciplinary actions on cases pending as of January 1, 1978 is given in Table 3.

*Table 3: Outcome of Adjudicatory Cases*

<table>
<thead>
<tr>
<th>Action</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>License Revocations</td>
<td>7</td>
</tr>
<tr>
<td>Resignations</td>
<td>3</td>
</tr>
<tr>
<td>Exoneration</td>
<td>2</td>
</tr>
<tr>
<td>Case Dismissed</td>
<td>2</td>
</tr>
<tr>
<td>Censure</td>
<td>1</td>
</tr>
<tr>
<td>Order to Show Cause Withdrawn</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

Ten cases that were pending on January 1 still remain to be resolved. The number of cases carried over from preceding years is given in Table 4. Finally, a breakdown of the types of complaints docketed with the Board is found in Table 5. The disposition of cases by type of complaint is given in Appendix D.

*Table 4: Cases Pending From Previous Years*

<table>
<thead>
<tr>
<th>Year</th>
<th>New Orders to Show Cause Issued</th>
<th>Cases Carried Over From Preceding Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>25</td>
<td>—</td>
</tr>
<tr>
<td>1977</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>1978</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>1979</td>
<td>—</td>
<td>21</td>
</tr>
</tbody>
</table>
Table 5: Types of Complaints Docketed by the Board of Registration in Medicine, Fiscal Year 1978

**JURISDICTIONAL — Negligent or Misdiagnosis**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negligent treatment</td>
<td>45</td>
</tr>
<tr>
<td>Misdiagnosis</td>
<td>9</td>
</tr>
<tr>
<td>Malpractice</td>
<td>4</td>
</tr>
<tr>
<td>Gross negligence</td>
<td>1</td>
</tr>
<tr>
<td>Sexual involvement</td>
<td>3</td>
</tr>
<tr>
<td>Fraud</td>
<td>9</td>
</tr>
<tr>
<td>Billed for services not rendered</td>
<td>9</td>
</tr>
<tr>
<td>Drug cases</td>
<td>14</td>
</tr>
<tr>
<td>Drug &amp; Alcohol</td>
<td>1</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>3</td>
</tr>
<tr>
<td>Others: P.A. supervision</td>
<td>2</td>
</tr>
<tr>
<td>Acupuncture supervision</td>
<td>3</td>
</tr>
<tr>
<td>Drug research</td>
<td>1</td>
</tr>
<tr>
<td>Medical emergency</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>14</td>
</tr>
<tr>
<td>Gross misconduct</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total** 67

**QUESTIONABLE JURISDICTION**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid refusal</td>
<td>1</td>
</tr>
<tr>
<td>Refusal to complete forms</td>
<td>3</td>
</tr>
<tr>
<td>Others: Rude verbal treatment</td>
<td>6</td>
</tr>
<tr>
<td>Practicing without a license</td>
<td>7</td>
</tr>
<tr>
<td>Fee dispute</td>
<td>2</td>
</tr>
<tr>
<td>Withholding medical records fee unpaid</td>
<td>6</td>
</tr>
</tbody>
</table>

**Total** 21

**TOTAL COMPLAINTS RECEIVED FOR FISCAL 1978 — 153**

Source: Complaint ledger Board of Registration in Medicine 9/28/78
MEDICAL MALPRACTICE TRIBUNALS

The medical malpractice tribunal system continued its consistent performance during 1978. The tribunals were created by Chapter 362 of the Acts of 1975 to screen out unwarranted or frivolous malpractice suits at an early stage of judicial proceedings. Table 6 presents the results of the most recent survey of tribunal dispositions recorded as of August 1, 1978. As the summary in Table 7 indicated, 45.4 per cent of the cases brought before the tribunals had the bond requirement imposed as a prerequisite for any further judicial consideration. Another 9.2 per cent of the tribunal cases had split decisions which imposed the bond requirement for one or more (but not all) of the defendants in the case. In the 314 cases in which bonds were required, only 72 bonds (23 per cent of the 314, 12.5 per cent of the total number of tribunal cases) were filed to permit the plaintiffs to continue their suits. As a result, between 189 and 242 cases, amounting to between 33 and 42 per cent of the total tribunal caseload, have been entirely excluded from the court system.

Table 6: Dispositions of Medical Malpractice Tribunals

<table>
<thead>
<tr>
<th>County</th>
<th># of Cases</th>
<th># of Cases Sufficient</th>
<th>Not Sufficient</th>
<th>Bond Filed</th>
<th>Split Decision</th>
<th>Tribunal Forthcoming</th>
<th>Dismissed Prior to Tribunal Hearing</th>
<th>No Hearing Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnstable</td>
<td>19</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Berkshire</td>
<td>16</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Bristol</td>
<td>39</td>
<td>10</td>
<td>19</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Dukes</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Essex</td>
<td>93</td>
<td>15</td>
<td>19</td>
<td>4</td>
<td>2</td>
<td>40</td>
<td>12</td>
<td>5</td>
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<tr>
<td>Franklin</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Hampden</td>
<td>79</td>
<td>26</td>
<td>24</td>
<td>5</td>
<td>8</td>
<td>5</td>
<td>9</td>
<td>7</td>
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<tr>
<td>Hampshire</td>
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<tr>
<td>Middlesex</td>
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<td>77</td>
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<td>28</td>
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<tr>
<td>Norfolk</td>
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<td>Plymouth</td>
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<td>Suffolk</td>
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<td>7</td>
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<tr>
<td>Worcester</td>
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<td>1</td>
<td>18</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>U.S. Dist. Ct.</td>
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<td>0</td>
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<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>916</td>
<td>261</td>
<td>261</td>
<td>72</td>
<td>53</td>
<td>184</td>
<td>100</td>
<td>57</td>
</tr>
</tbody>
</table>

As of August 1, 1978
Table 7: Summary of Tribunal Outcomes
(Statewide)

<table>
<thead>
<tr>
<th>Total Tribunals Held</th>
<th>Insufficient Findings (Bond Required For Further Court Action)</th>
<th>Split Decisions (Bond Required For Proceeding Against Some Defendants)</th>
<th>Cases In Which Bond Was Filed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Of Cases</td>
<td>575</td>
<td>261</td>
<td>261</td>
</tr>
<tr>
<td>Percent Of Total</td>
<td>100.0</td>
<td>45.4</td>
<td>45.4</td>
</tr>
</tbody>
</table>

As part of the most recent survey of tribunal dispositions, the Special Commission collected data for the first time on the amount of bond actually filed. The results of the survey of bond filings is given in Table 8. Of the seventy-two cases in which the bond requirement was imposed, 28 cases (38.9 per cent) resulted in reduced bonds being

Table 8: Bonds Filed in Malpractice Cases
1/1/76 — 7/11/78

<table>
<thead>
<tr>
<th>Number Of Cases</th>
<th>Amount Of Bond Filed</th>
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<tbody>
<tr>
<td>44</td>
<td>$2,000</td>
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<tr>
<td>9</td>
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<tr>
<td>1</td>
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<td>$150</td>
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<td>$100</td>
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<td>$50</td>
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<td>2</td>
<td>$1</td>
</tr>
<tr>
<td>1</td>
<td>Waived</td>
</tr>
</tbody>
</table>

Totals 72 $101,852
required of the plaintiff to proceed further with the case. In the remaining 44 cases, the full $2,000 bond amount was imposed, as stipulated in MGLA Chapter 231, Section 60B. Section 60B allows the bond requirement to be reduced upon a determination by the court that the plaintiff is indigent. The average bond amount required in the 72 cases was $1,415. In the 28 cases in which the bond requirement was reduced, the average amount imposed was $495.

It should be noted that the "number of cases" used in the bond survey includes cases in which bonds were required for each of a number of defendants to a single malpractice suit. In the bond survey, suits of this type were treated as though they included a "number of cases" equal to the number of defendants for which the bond requirement was imposed. Thus, the number of malpractice suits that have been kept open by the filing of a bond is actually somewhat less than 72 and the number of suits eliminated entirely from the system is correspondingly greater. Because of differences in record-keeping systems in the various county courts, we have been unable to ascertain the exact amount of the discrepancy. The effect of the discrepancy, however, is to understate the effectiveness of the tribunals in eliminating cases from the system by an amount somewhere between one and nine per cent of the total number of cases that reached disposition by the tribunals.

In a separate survey, the Special Commission has collected data describing the length of time elapsed between the date of filing of answers to malpractice suits and the date on which the tribunal hearings were held. This information was collected for malpractice suits against physicians filed in Middlesex, Norfolk and Worcester Counties. The results of this sampling are given in Table 9, broken down according to whether the tribunal reached a "sufficient" or "insufficient" finding. In 1976 and 1977, the time elapsed between answer and hearing was greater in cases which reached "insufficient" findings than in those which reached "sufficient" findings. In 1977, the difference was particularly large, with "insufficient" cases taking 32 days longer to reach the hearing than "sufficient" cases. This discrepancy reversed direction in 1978, however, leaving the Special Commission unable to ascribe it to any particular vagary in the tribunal process.
Table 9: Average Number of Days: Answer to Tribunal

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>1976</th>
<th>1977</th>
<th>1978**</th>
<th>Overall Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TS* TI</td>
<td>TS TI</td>
<td>TS TI</td>
<td>TS TI</td>
</tr>
<tr>
<td>Middlesex</td>
<td>45.9 45.0</td>
<td>51.9 87.0</td>
<td>50.3 48.0</td>
<td>49.4 60.0</td>
</tr>
<tr>
<td>Norfolk</td>
<td>53.9 71.0</td>
<td>98.4 153.8</td>
<td>45.5 44.0</td>
<td>65.9 89.6</td>
</tr>
<tr>
<td>Worcester</td>
<td>64.0 48.9</td>
<td>128.0 162.8</td>
<td>48.7 22.0</td>
<td>80.2 77.9</td>
</tr>
<tr>
<td>Column Average</td>
<td>54.6 55.0</td>
<td>92.8 134.5</td>
<td>48.2 38.0</td>
<td>65.2 75.8</td>
</tr>
<tr>
<td>Yearly Overall Average</td>
<td>54.8</td>
<td>104.0</td>
<td>44.5</td>
<td>67.8</td>
</tr>
</tbody>
</table>

TS — Sufficient Finding
TI — Insufficient Finding

*Sufficient cases include split decisions which imposed the bond requirement for some but not all defendants.

**Data for 1978 was collected early in the year, accounting for the smaller average delay.

The average length of time overall was 68.7 days between answer and hearing.

As indicated by the data reported above, the Special Commission concludes that the tribunal system is continuing its effective performance in eliminating substantial numbers of nonmeritorious malpractice cases at an early stage of judicial proceedings. Although the original statute specified a time limit of 15 days between answer and hearing, it is apparent that, as the tribunals have evolved, a more reasonable limit can be adopted without adversely influencing the effectiveness of the tribunals. It is conceivable that implementation of various aspects of the court reform bill that passed into law last year may allow a speed-up in the tribunal process. But at this juncture, it seems reasonable to extend the statutory limit to 60 days.

**Recommendation:** The statutory time limit between the date of filing of the answer to a malpractice complaint and the date of a malpractice tribunal hearing should be changed from 15 to 60 days.

In addition to its regular examination of tribunal dispositions, the
Special Commission this year sponsored an indepth study of the procedural aspects of the tribunals. The study was intended to document the existing practice in tribunal procedures, to determine the extent to which procedures are uniform throughout the state, to examine the degree to which the procedures conform with the original intentions of the Legislature in passing Chapter 362 of the Acts of 1975 and to develop recommendations for procedural changes that might be necessary to assure the continuing effectiveness of the tribunals. To address these objectives, a wide range of interviews were conducted with individuals involved in the tribunal process, numerous tribunals were observed, and an extensive report was prepared that described the tribunal operations and prescribed a set of recommendations for consideration by the Special Commission. The report of the Tribunal Study is attached in its entirety as Appendix E. It was prepared for the Special Commission by Ms. Elaine Lubin as part of the Spring Exercise Program of the Kennedy School of Government at Harvard. Portions of the report are included in the discussion of the recommendations that follows.

The Special Commission has adopted the recommendations suggested in the Tribunal Study in five areas: selection of tribunal members, conduct of tribunal hearings, bond requirements, dismissal procedures, and procedures at subsequent trial.

**Selection of Tribunal Members.** The statutory restrictions on selection of the doctor member of the tribunal are, for the most part, unnecessary and burdensome. Since the doctor is included on the tribunal to represent the field of medicine in which the injury occurred, the additional requirement that he be a licensed surgeon is superfluous. In practice, as potential conflicts of interest are resolved in the scheduling process, there is no need for the further requirement that the doctor sitting on the tribunal not practice in the county where the defendant practices or resides.

**Recommendation:** The Special Commission recommends that the statutory requirements for membership on the tribunal be amended as provided in Appendix F of this Report.

As stipulated in Chapter 362, “where the action of malpractice is
brought against a provider of health care not a physician, the physician’s position on the tribunal shall be replaced by a representative of that field of medicine in which the alleged tort or breach of contract occurred, as selected by the superior court justice in a manner he deems fair and equitable.” This paragraph is currently being interpreted to require that cases brought against a hospital be heard by a hospital administrator. However, as administrators are not necessarily versed in medicine, they are frequently unable to provide the infusion of expertise into the tribunal process that was envisioned by the Legislature in requiring a health care representative on the panel. Since a hospital does not constitute a “field of medicine”, selection of a doctor rather than a hospital administrator is preferable whenever the medical issues in such a case threaten to be particularly complex.

**Recommendation:** Doctors or representatives of other appropriate “fields of medicine” should be selected as representatives of medicine in all tribunal cases where the issue is solely one of physician negligence. Where the hospital corporation is the sole defendant or the co-defendant and the issues relate to management, supervision, or general hospital administration, a hospital administrator shall be selected.

A final issue in the selection of tribunal members arises when justices presiding at tribunal occasionally designate more than one doctor to sit on a panel when a case involves various defendants of diverse medical specialties. Each doctor sits solely with regard to the defendant in his field, so that, in essence, the proceeding consists of several separate tribunals with overlapping memberships sitting simultaneously. Chapter 362 makes no explicit provision for this procedure, only stating that “where there are codefendants representing more than one field of health care the superior court justice shall determine in his discretion who shall represent the health care field on the tribunal”. The Special Commission believes this practice to be a logical and efficient response to a complex situation, permitting the tribunal to address all relevant medical issues at one time with an informed membership.

**Conduct of the Hearing.** The Special Commission adopts the recommendations contained in the “Conduct of the Hearing and Deliberations on the Tribunal”.
tion by the Tribunal" section of the Tribunal Study. (See discussion in Appendix E, pp. 51-53.) Together these recommendations describe a hearing process designed to be brief, to assure that evidence exists on all pertinent claims of the defendant, and to bring the particular expertise of the tribunal members to bear on the issues presented in the case. The recommendations adopted by the Special Commission are:

(1) Oral testimony should be avoided in all but the most unusual circumstances.

(2) The plaintiff's attorney should be permitted at least 20 minutes of oral presentation, and should present substantial evidence on each element of his claim.

(3) The defendant's attorney should be permitted to submit evidence and to make a brief oral statement directed to gaps and inconsistencies in the plaintiff's offer of proof.

(4) Evidence on disputed questions of fact is irrelevant to the issues before the tribunal, unless it rises to the level of legal significance. The tribunals are not intended to dispose of plausible suits on the merits.

(5) The physician member should be permitted to comment on general medical practice and on the particular features of the plaintiff's case based on the judge's instruction, delivered in open court, as to the applicable standard of proof.

(6) When the physician member's opinion contradicts evidence provided by the plaintiff, it should not sway the tribunal from viewing the plaintiff's case in the most favorable light possible.

(7) The physician member should be permitted to substantiate a plaintiff's claim, even though the plaintiff technically did not meet the directed verdict standard since the tribunal should not find against the plaintiff in the face of knowledge of evidence sufficient to substantiate his claim.

**Bond Requirement.** Upon reaching a finding that the plaintiff failed to present evidence to the tribunal sufficient to warrant additional judicial inquiry, the tribunal is authorized to impose a bond requirement on the plaintiff if he or she wishes to proceed further with the case. Imposition of the bond requirement is intended to accomplish two objectives: discourage unnecessary litigation on nonmeritorious cases and compensate defendants who are forced to litigate nonmeri-
turous claims despite a finding in their favor by the tribunal. It is currently the practice, in cases with multiple defendants, to allow the imposition of the bond requirement to be leveled against the plaintiff separately for each defendant that received a favorable ruling from the tribunal. This practice is in accord with the objectives of the tribunal system and should be continued, at the discretion of the judge, in cases where the plaintiff has clearly included as defendants individuals who had no connection with the incident in question. However, to go further and impose a separate bond for each count of a plaintiff's claim against a particular defendant would be to impose an unduly harsh burden on the plaintiff in excess of the deterrent effect anticipated by the tribunal legislation. The Special Commission, thus, recommends that this latter use of the bond requirement not be employed by tribunals since it goes beyond the scope of the original legislation.

*Dismissal Procedure.* Under current procedures, a tribunal finding in favor of the defendant will not result in dismissal of the case until the defendant files a motion for dismissal and that motion is granted by the court. This practice is time consuming and burdensome both to the defendant, who must bring the motion, and to the courts, which must hear it. A more efficient procedure would be to dismiss the complaint automatically within 30 days of an adverse tribunal finding if the plaintiff fails to meet the bond requirement or take other actions to keep the case open. The Special Commission believes that this automatic dismissal proceeding is within the scope of the original legislation and is in accord with the objectives of the tribunals. Therefore we recommend that the automatic dismissal procedure be adopted by rule of court.

*Procedures at Subsequent Trial.* The original tribunal legislation provides that the tribunal finding will be admissible as evidence at subsequent trial. However, since the tribunal finding does not represent a finding on merits of the case, the Special Commission believes it imperative that any resulting prejudice to the party losing at tribunal should be minimized by issuance of appropriate instructions to the jury. Specifically, the tribunal's decision should be given no special weight as evidence in the course of jury deliberations, and they should be told that the statute does not endow the finding with any compelling legal force.
Along these lines, the Special Commission believes that the testimony of expert witnesses subpoenaed at hearing should not be admissible as evidence at trial. This suggestion may be relaxed if the expert was subject to cross examination by all parties before the tribunal. However, permission of cross examination would considerably lengthen the hearing stage, and thereby thwart the intention of the original tribunal legislation to devise a speedy and informal screening process.

Recommendation: The Special Commission recommends that the statute be amended to prohibit admission of testimony taken at the tribunal hearing as evidence at trial, except to impeach the testimony of an expert witness.

Finally, if the plaintiff's presentation at trial differs significantly from the contents of his offer of proof, defendant should be permitted to submit transcripts of the hearing in order to point out these deviations.

The Special Commission has decided to make no recommendations at this time with respect to four of the issues raised in the Tribunal Report — discovery procedures, standard of proof at tribunals, appeals from tribunal findings and admissibility of tribunal findings at subsequent trials. The discovery and standard of proof portions of the report were addressed to clarification of existing procedures, which had been subject to varying application as a result of uncertainty about the appropriate interpretation of Chapter 362. However, these uncertainties were largely eliminated by the decision in a recent case before the Supreme Judicial Court. In the case of Little v Rosenthal, 382 N.E. 2d 1037 (1978), the Court interpreted the tribunal statute as requiring the plaintiff to present evidence to the tribunal sufficient to withstand a motion for directed verdict in favor of the defendant. The Court's adoption of the directed verdict standard implicitly acknowledges a somewhat expanded role for the gathering of evidence prior to the tribunal hearing. The Special Commission welcomes the procedural uniformity which this decision promises to create. However, we wish to emphasize that the tribunals are intended to serve as preliminary screening mechanisms to reduce the overall litigation costs in malpractice cases. Thus, it is important that evidentiary proceedings prior to the tribunal hearings not be expanded to an extent that will frustrate this overall purpose of the tribunal system.
SUMMARY

From its examination of the operation of the Chapter 362 reforms, the Special Commission has concluded that stability has returned to virtually all of the components of the Massachusetts malpractice system. The rapidly increasing trends in malpractice claims incidence and severity that were perceived with great trepidation several years ago have been reversed in recent years. This reversal has become accepted as fact to a sufficient extent that it has been incorporated into the most recent rate-setting procedure by common stipulation of all the involved parties. The availability of malpractice coverage has been guaranteed by Chapter 362, and the cost of this coverage is subject to strict regulation by the Division of Insurance. As a result, malpractice insurance is available to Massachusetts health care providers at very reasonable rates. Nonetheless, the quality of the regulatory process has preserved an ample measure of profitability for any insurer that might re-enter the Massachusetts market, as demonstrated by the rebate in premiums ordered by the most recent rate-setting decision.

The Board of Registration in Medicine has assumed a very important role in the health care system of Massachusetts through its licensing and regulatory activities. Having overcome initial funding and organizational difficulties, the Board has succeeded in adopting a wide-ranging and forceful set of rules and regulations governing the practice of medicine and has undertaken vigorous enforcement of them.

Finally, the malpractice tribunal system has continued its excellent performance in screening nonmeritorious cases out of the court system. The opportunity for an early hearing to consider the quality of a particular malpractice claim, coupled with the imposition of the bond requirement in cases found to be lacking in merit, has substantially reduced the burden placed on the judicial system by malpractice cases. In addition, the tribunal system is an important step toward reducing the overall cost of the malpractice system. That the tribunals accomplish their objectives while affording equitable treatment for aggrieved victims of actual malpractice is demonstrated by the favorable reception that the tribunals have received when their structure and operation have been challenged in appellate judicial proceedings.
In summary, then, the Special Commission concludes that the Chapter 362 provisions have been substantially successful in meeting the severe challenge of the malpractice crisis. However, there are four outstanding areas of concern that still require attention. First, the Commission notes that the crisis was substantially exacerbated by a lack of adequate information and data describing the malpractice system. This information is available today in useful form only to a limited extent. Second, the Commission also is troubled by the lack of response on the part of private insurers to the stabilized conditions in the Massachusetts malpractice market. We would like to reiterate our encouragement to private insurers to resume their operations in Massachusetts. Third, the Commission is disturbed about the extraordinary length of time required for a malpractice suit to reach disposition. Unless malpractice cases can be expedited, the Massachusetts system will continue to operate with the problem of the “long tail” of malpractice suits still unsolved. It was largely the fear of this “long tail”, coupled with inadequate data about current trends, that triggered the initial panic prior to the crisis of 1975. The Commission is optimistic that the recently adopted Court Reform Act will expedite judicial action in the Commonwealth.

Finally, the Commission wishes to state emphatically its understanding that the malpractice system is a component in a system of medical quality assurance. The problems of the malpractice system cannot be viewed in isolation from the difficult problems of assuring quality medical care for the citizens of the Commonwealth. Chapter 362 took important strides in this area through its revitalization of the malpractice mechanism. The Commission believes, however, that long-term stability can only be achieved by maintaining superior standards for the quality of medical practice and medical care in Massachusetts.

Table A1: Physicians and Surgeons — Occurrence Rates

<table>
<thead>
<tr>
<th>Rate Class</th>
<th>1978 Rate ($)</th>
<th>1979 Rate ($)</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>542</td>
<td>542</td>
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<tr>
<td>2</td>
<td>976</td>
<td>976</td>
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<tr>
<td>3</td>
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Table A2: Hospitals - Occurrence Rates*

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<td>1979</td>
<td>191</td>
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*In dollars per occupied bed.
The rate per 100 outpatient visits is 7.5% of the above rate per occupied bed.

Table A3: Physicians and Surgeons — Claims-Made Rates

<table>
<thead>
<tr>
<th>Rate Class</th>
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*Table A4: Hospitals — Claims-Made Rates*

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<th>Policy Type</th>
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*In dollars per occupied bed.
The rate per 100 outpatient visits is 7.5% of the above rates per occupied bed.
APPENDIX B
SPECIAL COMMISSION ON MEDICAL MALPRACTICE
August 22, 1978

SUMMARY OF: “A Management Audit of the Board of Registration and Discipline in Medicine”, by Mark D. Abrahams, Assistant to the Comptroller.

This study was performed by the Comptroller’s Office as part of their general program to implement “management by objective” procedures in executive branch agencies. The Board of Registration and Discipline in Medicine was selected for study in the Fall of 1977 as being representative of the 27 boards of registration within the Division of Registration. The study evaluated the Board's functional organization, its personnel arrangements, its financial relations with the Division and its allocation of personnel to particular functions. The major subject of criticism expressed by the auditor was the general lack of management capabilities within the Board, arising from uncertainties about budgeting and hiring procedures, from a shortage of administrative personnel, and from an ambiguous and erratic relationship to the Division. As evidence of the need for enhanced management capabilities, the report cites an increasing work backlog, long delays in processing applications, and chaos in license renewal procedures.

Most of the findings and recommendations contained in the report concern procedural matters such as record keeping and clerical administration and are therefore outside the interests of the Special Commission. However, the findings concerning the Board's financing and its relationship to the Division of Registration may prove to be somewhat controversial in light of the difficulties that the Commission has previously noted in these areas.

The financial section of the report begins with the observation that the Board collects more revenue than it expends in both renewal and non-renewal fiscal periods. In FY 1975, when license renewals were not scheduled, the Board's revenues and expenditures were $160,684 and $89,501, respectively, leaving a surplus of $71,183. In FY 1976, a license renewal period, the corresponding figures were $843,384 and $115,263,
for a surplus of $728,121. The report indirectly identifies what may be a major source of the Board's difficulties when it describes the different budgeting procedures for the Board's licensing and disciplinary functions. The licensing function is currently budgeted through the Division, with no allocation made directly to the Board. Thus, a portion of the licensing function is performed by Division personnel rotating among the various Boards within the Division. When the disciplinary responsibilities were added to the Board by Chapter 362, no additional appropriation was made within the Division for its support services, although an executive secretary and two investigators were added to the personnel roster. As a result, the Board was forced to file in FY 1978, a revised supplemental budget for $92,706 to meet the responsibilities of its disciplinary function. This budget request was not supported by the Division or the Secretary of Consumer Affairs and the Board eventually had to go directly to the legislature for the $80,000 it received for its disciplinary function. There is no apparent assurance that the disciplinary function would have been funded otherwise through the Division's budget. In addition, no firm agreement had been worked out between the Board and the Division as to what licensing expenditures would be covered under the Division's budget and, as a result, hiring and expenditure procedures at the Board have been chaotic.

Despite (or because of) this history of uncomfortable relations between the Board and the Division on budgetary matters, the report recommends that "The Disciplinary Account of the Board should be transferred to the Division. This procedure will eliminate duplicate records and will enhance budgetary control at the Division level." The report also recommends "a greater involvement by the Division in administration" of the Board, including computerization, personnel training and the like.

Given the political and administrative difficulties that the Board has faced in past dealings with the Division, the particulars of a budgetary and administrative transferral such as proposed by the Comptroller's Office deserve close scrutiny. It should be noted that none of the recommendations appear to address the problems currently faced by the Board in their attempts to prosecute the Malden Hospital thoracic
surgery case. The Board currently expects that case alone to cost $100,000 because of its technical and legal complexities and there presently is no indication of where the funds will come from. Attempts were unsuccessful to get a specific item included in the FY 1979 budget. The Board is now faced with the alternatives of seeking discretionary funds from the Division or seeking a supplement to their budget in a forthcoming deficiency budget (or dropping the case entirely). None of these alternatives are especially appealing.
His Excellency Michael S. Dukakis
Governor of Massachusetts
State House
Boston, Massachusetts 02133

Dear Governor Dukakis:

We are, once again, writing you out of concern for the budgetary and administrative problems of the Board of Registration and Discipline in Medicine. We wish to bring to your personal attention two matters that we believe threaten the viability of the Board to fulfill its obligation of assuring the quality of medical practice in Massachusetts.

The first matter concerns the relationship of the Board of Registration and Discipline in Medicine (BRDM) to its parent agency, the Division of Registration. As you know, the BRDM is one of some twenty-seven boards of registration for various state-licensed occupations and enterprises included under the direction of the Division. As such, it is budgeted partly through the Division for the BRDM’s registration function and partly through a direct account to cover the BRDM’s disciplinary function.

Until recently, the Special Commission on Medical Malpractice, whose responsibilities include monitoring the BRDM, never fully understood the reasons for this budgetary distinction. However, we have just received and reviewed a management study of the BRDM prepared by the Comptroller’s Office which, in part, details the Division’s budgetary proceedings since the Board’s inception in 1976, and what we have discovered through this report is very disturbing. In very brief summary, it appears as though both of the BRDM’s functions were supposed to have been budgeted through the Division’s account, but the Division and the Secretary of Consumer Affairs have never, in the three fiscal years to date, been able to agree in negotiations with the Board to an amount to be budgeted for the disciplinary function. In at least one of these years, this disagreement resulted in no funding being recommended for the disciplinary function in the Governor’s Budget.
Message. In the other years, the Executive Branch budget recommendations proved to be seriously inadequate. As a result, the legislature (in particular Representative LaFontaine and myself) had to intervene in the budgetary process to assure funding for the disciplinary function. In short, the BRDM's history of budgetary difficulties apparently demonstrates a very disturbing lack of sensitivity on the part of the Executive Branch (especially on the part of the office of the Secretary of Consumer Affairs, and, through them, the Division of Registration) concerning the necessity of maintaining a strong disciplinary component for the Board. This insensitivity calls into severe question the degree of commitment of the Executive Branch to the assurance of quality health services for the citizens of the Commonwealth. To make matters worse, the Comptroller's Report goes on to recommend that the Board's administrative and budgetary functions be entirely incorporated into the Division, which could only serve to make the Board more susceptible to future interference with its operations.

The second matter that we seek to bring to your attention relates closely to the preceding discussion. Partly as a result of the general budgetary problems outlined above, and partly because of uncertainties about the proposed consolidation of the Division of Registration, the BRDM was unable to obtain funding for pursuit of the so-called Malden Hospital case. In this case, a group of surgeons are under investigation for apparently substandard open-heart surgery practices that resulted in a substantially higher-than-expected mortality rate for their operations. Needless to say, this is an extraordinarily complex case. The case promises to have broad significance in future assessments of medical competence and has already attracted nationwide attention in consideration of its potential impact. It is also a very expensive case to pursue, far outstripping the present budget of the Board, thus requiring the Board to request supplemental funding from the Secretary of Consumer Affairs, without which the case will have to be dropped.

We are attempting in this letter to inform you directly of these circumstances and to appeal for more active support from the Executive Branch for the disciplinary functions of the Board. In the absence
of a demonstrated change in the attitude of the administration, the
Special Commission is fearful that, if the Board's budget is placed more
firmly under the Division's control, the Board will receive even less
deferece to the importance of its disciplinary activities, which are
unique in comparison to the other boards of registration within the
Division. Moreover, unless the budgetary reins are loosened on the
Board's disciplinary function, we are fearful that the decision to prose-
cute such cases as that of Malden Hospital may be subject to untoward
considerations. To guard against interventions in this decision process
for reasons other than the facts of the disciplinary case at hand, the
Special Commission believes that the Board needs more independence
from the ordinary division budgetary process, not less.

We respectfully request your attention to the issues raised in this
letter. The Special Commission will conduct a hearing on these and
other issues relating to the Board in mid-October and we would be very
interested in obtaining your thoughts and recommendations prior to
the hearing as to how best we might approach this problem.

Sincerely yours,

Senator Daniel J. Foley
Chairman

Representative Raymond M. LaFontaine
Vice Chairman

October 16, 1978

Senator Daniel J. Foley
Chairman
and Representative Raymond M. LaFontaine
Vice-Chairman
Commonwealth of Massachusetts
Special Commission on Medical Malpractice
General Court of Massachusetts
State House, Room 257
Boston, Massachusetts 02133

Dear Senator and Representative:

I would like to clarify the issues raised in your recent letter concerning
the Board of Registration and Discipline in Medicine.
I am fully aware of the budgetary connection between the Board and the Division of Registration, and more particularly the fact that the Board has received part of its funds from the Division. I am, further, familiar with the Comptroller’s Office management study of the Board, specifically designed to aid the Board and the Division in the proper administration and budgeting of the Board. To the extent that the Comptroller’s report recommends incorporation of the Board’s budgetary functions into the Division, that recommendation has been for the purpose of giving the Board a greater ability to perform all of its functions.

With respect to the Malden Hospital case, you may be assured that this Administration fully shares your view that this complex case is of immense importance. The Division of Registration and the Secretary’s office have been fully cooperative and supportive of the Board’s requests for funds to pursue this case. Where necessary, the Secretary has supported 03 and other contracts submitted by the Board in the amount deemed necessary by the Board.

The Board, as you know, has requested a substantial increase in its budget for Fiscal Year 1980. You should be aware that the Division and the Secretary have concurred in this augmented budget, which includes additional personnel.

Your concern for the Board and its proper functioning is completely understandable. I hope I have clarified any misconception you may have had about our support for the Board.

Sincerely,

Michael S. Dukakis

c: Secretary Sullivan
### APPENDIX D

**Complaint Dispositions By Type Of Complaint.**

**Board Of Registration And Discipline In Medicine, FY 1978**

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<th>Description</th>
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<th>Cited</th>
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* 1 Case Involves 7 Physicians
To: Michael Thomas  
From: Elaine Lubin  
Re: Procedural Guidelines for Medical Malpractice Tribunals

The Problem

Massachusetts medical malpractice tribunals were designed to screen non-meritorious malpractice suits out of the court system at an early stage of proceedings and thereby reduce the cost of the malpractice system and the backlog of malpractice cases within the Massachusetts courts. While the tribunals have apparently succeeded in reducing the number of malpractice cases progressing to full trial, this success has been achieved amid considerable confusion over the proper procedures to be followed in tribunal hearings. The enabling legislation is silent or unclear on such crucial issues as the permissibility of pre-hearing discovery, the applicable standard of proof, the role of defense counsel, and the appealability of tribunal decisions. Other clearly regulated procedural matters, such as the time period allotted for convening a tribunal, and the admissibility of tribunal findings as evidence at subsequent trial, have engendered notable controversy. To the extent that this state of affairs has led different tribunals to adopt differing procedures, it has created unnecessary uncertainty among litigants and may have resulted in the dismissal of cases which, under uniform guidelines, would never have received an adverse ruling at the tribunal stage.

Fairness and efficiency require that these uncertainties be laid to rest. The procedures followed by the various tribunals should be uniform in all significant respects, and available in advance of the hearing to all participants in the process. As the body charged by the General Court with monitoring the implementation of the malpractice legislation, the Special Commission on Medical Malpractice should,
accordingly, formulate and promote the adoption of guidelines for the fair, efficient, and consistent operation of the tribunal system.

**Constraints**

In order to be acceptable to the legislature and the judiciary, any procedures devised by the Commission should:

- conform to the intent of the authorizing legislation;
- accord with existing practice as closely as possible; and
- safeguard the legitimate concerns of all interested parties.

**Legislative Intent.** In passing the legislation which authorized the malpractice tribunal system, the General Court sought to ensure the continued availability of high quality medical care throughout the Commonwealth, despite the threat to health care created by an imminent crisis in the malpractice insurance industry. Medical malpractice tribunals, in particular, were designed to address that crisis, reducing the cost of malpractice insurance by decreasing the risk of and costs associated with unwarranted malpractice suits. According to available legislative history, they were intended to be fast, inexpensive mechanisms for determining at the outset of a case whether or not there was probable cause that the named defendant was in fact liable for malpractice. In the interests of both speed and economy, hearings were to be streamlined and informal, avoiding such peculiar characteristics of the trial by jury as extensive oral testimony and strict rules of evidence.

**Existing Practice.** Most of the procedures followed by malpractice tribunals fall within the broad outlines set forth in the authorizing legislation. In accordance with the dictates of Massachusetts General Laws Chapter 231, Section 60B (see Appendix 1), each tribunal consists of a single justice of the Superior Court, a doctor drawn from the relevant medical specialty, and a lawyer drawn from a list submitted by the Massachusetts Bar Association. The tribunals hear the plaintiff's "offer of proof" in "every action for malpractice, error or mistake against a provider of health care" within, if not fifteen days, at least a reasonable period of time after the defendant's answer has been filed. They then make a determination either that "the evidence presented if properly substantiated is sufficient to raise a legitimate question of
liability appropriate for judicial inquiry” or, in the alternative, that the “plaintiff's case is merely an unfortunate medical result.” If the tribunal finds for the plaintiff, the case proceeds to trial without incident. If, however, the tribunal finds for the defendant, the plaintiff “may pursue the claim through the usual judicial process only upon filing bond in the amount of two thousand dollars . . . payable to the defendant for costs assessed . . . if the plaintiff does not prevail in the final judgment.” The amount of this bond may be increased at the discretion of the presiding justice, or reduced upon a showing by the plaintiff that he is indigent, but may not be eliminated altogether. Failure to post bond within 30 days results in dismissal of the case. The decision of the tribunal, be it for the plaintiff or for the defendant, is admissible as evidence at subsequent trial.

A detailed description of the process of an uneventful tribunal hearing is provided in Appendix 2. Procedures which are controversial or which differ significantly across tribunals are highlighted in Appendix 3, and discussed in greater depth in the course of my recommendations, which begin on page 41.

Legitimate Concerns of Interested Parties. The key participants in medical malpractice tribunals are health care providers, patients, and the courts. Broadly delineated, the interests of these groups are frequently in conflict. However, their concerns may legitimately be accommodated by malpractice tribunals only insofar as they comport with the tribunals' fundamental objective — expediting the progress of ordinary fault-based tort litigation in medical malpractice cases. In this area, the fault-based system of litigation serves two main functions: first, it permits the compensation of patients for injuries they should not have received and expenses they should not have incurred; and, second, it provides a mechanism for internalizing the real cost of poor medical practices into the operating costs of practitioners, creating an economic incentive for the health profession to police the quality of care provided by its members. Keeping these ultimate objectives in mind, it is fairly simple to outline the legitimate concerns of the three groups directly affected by tribunal proceedings.
As defendants, health care providers have a legitimate interest in avoiding the harassment and expense of defending frivolous or non-meritorious malpractice suits. This interest is reflected in their desire to keep the cost of malpractice insurance as low as possible. While health professionals do take pride in maintaining an acceptable standard of medical care throughout the Commonwealth, they are generally of the opinion that tort litigation is not the most effective means of accomplishing this goal.

As plaintiffs, patients have an interest in the availability of remedies, judicial or otherwise, for injuries suffered in the course of medical treatment. However, as consumers of health care services, they are also concerned with obtaining high quality medical care at the lowest possible prices. Since the cost of malpractice insurance is frequently passed on to the patient through higher fees, this last concern aligns them with the medical profession to a limited extent.

Finally, the courts are particularly interested in reducing the burden of malpractice cases on the judicial system. At the same time, however, they wish to avoid foreclosing valid claims, and seek to provide a just and impartial forum for the resolution of genuine disputes.

Recommendations. While existing tribunal procedures are controversial in many respects (see Appendix 3), four major areas of systemic uncertainty may be singled out as worthy of particular scrutiny and possible remedial action. These are: the permissibility of discovery proceedings prior to hearing; the applicable standard of proof; the existence of an appeals process; and the admissibility of the tribunal's decision at subsequent trial.

**Discovery**

**Issue:** Should the plaintiff in a malpractice case be permitted to conduct discovery, and in particular depose witnesses, prior to hearing by a malpractice tribunal?

**Discussion:** Those opposed to this practice argue that the statute clearly contemplates a preliminary hearing held without benefit of prior discovery. This argument rests on both strict statutory interpretation and an independent analysis of legislative intent. The legislative requirement that all hearings be held within 15 days after the defend-
ant’s answer is filed does not, as a practical matter, provide sufficient
time for the plaintiff to depose witnesses.* Accordingly, it may be
inferred that discovery was not intended to take place until after the
conclusion of tribunal proceedings. Since discovery is generally consi-
dered part of the “usual judicial process,” this inference is supported by
the statutory provision that a plaintiff who loses at the tribunal stage
“may pursue the claim through the usual judicial process only upon
filing bond. . . .” (Appendix 1, lines 52-53.) This may be interpreted to
read that the right to discovery is among the features of the litigation
process which may be forfeited by failure to post bond. Since a right
cannot be forfeited if it has already been exercised, the implication,
again, is that all discovery must be postponed until after the hearing.
Such an interpretation comports with the avowed intent of the tribunal
legislation to screen out nonmeritorious claims at an early stage in their
progress through the courts so as to reduce the costs of defending these
cases to a bare minimum. Since preparation for depositions taken by
the plaintiff may be expensive for the defendant, granting the plaintiff
unlimited recourse to such procedures prior to hearing could poten-
tially undermine achievement of the minimal cost objective. At the
same time, routine admission of depositions into evidence at tribunal
could conceivably transform hearings into minitrials on the merits.

Proponents of pre-hearing deposition argue that refusal to permit
this practice could ultimately result in the foreclosure of valid claims.
Justices both for and against this procedure cite instances in which they
felt the plaintiff had a good case but was unable to provide sufficient
substantiating evidence to prevail at hearing without first deposing the
defendant. The authorizing legislation for malpractice tribunals does
not explicitly prohibit pre-hearing deposition, and the statutory argu-
ment for barring it across the board is somewhat strained. Moreover,
one of my sources suggests that a plaintiff might be able to circumvent
any implied prohibition of discovery contained in the act by seeking
recourse in a [bill of discovery in equity]. This procedure arguably falls

*Massachusetts Rules of Civil Procedure provide that the defendant’s answer must be filed within 20 days after
service of the complaint, unless otherwise provided by order of court. M.R.C.P. 12(a)(1). Yet, the plaintiff may
not depose witnesses without leave of court until 30 days after service of the complaint unless the defendant has
already initiated similar proceedings. M.R.C.P. 30. Thus, the rules of civil procedure which govern the
discovery process, when coupled with the 15-day requirement in the malpractice tribunal enabling legislation,
permit the plaintiff only 5 days in which to take depositions prior to hearing.
outside the "usual judicial process," and therefore would not be included in the rights intended to be forfeited by a plaintiff who loses at tribunal and subsequently fails to post bond. Since the Massachusetts courts have held that the equitable bill for discovery was not curtailed by the enactment of extensive rules governing the discovery process, they are unlikely to hold it curtailed by implication in the malpractice area.

Recommendation: The plaintiff in a malpractice case should be permitted to initiate discovery prior to the hearing by a tribunal, but his right to do so should be limited rather than absolute. In this way, the danger of foreclosing valid claims may be balanced against the danger of causing the defendant unnecessary expense. If legislative amendment is feasible, I would recommend placing an arbitrary ceiling on the number of depositions permitted each plaintiff in advance of hearing. Provision for a single deposition, for example, would significantly curtail potential inconvenience to the defendant, and yet should provide the plaintiff with adequate opportunity to substantiate a valid claim. If amendment is not a viable option, the interests of both parties could be accommodated by permitting all uncontested discovery, while requiring that one party or the other make a showing to the court in support of any contention that further discovery should or should not be allowed. This course of action comports with current practices in certain tribunals, as well as the general thrust of the bill in equity for discovery, and could probably be implemented by rule of court. Nevertheless, it is not a completely optimal resolution of the discovery issue, since it threatens to enmesh the courts in prolonged pre-tribunal procedures inimical to the speedy resolution of malpractice litigation.*

Standard of Proof

Issue: What standard of proof should form the basis for the tribu-

*Since the presiding justice retains jurisdiction over the conduct of the tribunal, pre-hearing discovery need not necessarily result in the indiscriminate admission of depositions into evidence at hearing, and therefore the argument that discovery would transform the tribunal into a minitrial on the merits need not be addressed in the course of this recommendation.
nal's decision that a plaintiff either has or has not presented a legitimate question of liability appropriate for judicial inquiry?

Discussion: As indicated in Appendix 2, there are two major schools of thought on this issue. The first, focussing on the statutory reference to an “offer of proof,” maintains that plaintiff’s counsel should be required merely to describe the evidence he expects to present at trial. If the evidence so described, “if properly substantiated” at trial, would warrant denial of a motion for directed verdict against the plaintiff, the plaintiff should prevail at the tribunal stage. The second school of thought, arguing that this interpretation of the statute makes a mockery of the screening procedure by allowing any case to proceed to trial, holds that the plaintiff should only prevail if he makes out a prima facie case, that is, if he produces sufficient evidence at the hearing to warrant denial of a directed verdict if the case were already at trial. This standard is the civil counterpart to the finding of probable cause in a criminal case. Various other suggestions have been put forth from time to time, but have attracted little support. They include arguments that the plaintiff should prevail if his case is supported by a fair preponderance of the evidence presented at tribunal, as well as occasional attempts to frame a workable standard defining a less stringent requirement than the directed verdict test which is somewhat more forceful than the unsubstantiated offer of proof.

Recommendation: The direct verdict standard should form the basis for the tribunal’s decision. This standard comports with the intent of the authorizing legislation, is well-litigated and therefore easy to apply, should not result in undue prejudice to any party, and may be implemented by rule of court if so desired.

Permitting a plaintiff to prevail at hearing on the basis of unsubstantiated representations by counsel of the evidence expected to be presented at trial would make a mockery of the tribunal’s aim to weed out nonmeritorious suits at an early stage in proceedings. While the statutory reference to an “offer of proof” is confusing, much of the language and the available legislative history of the Malpractice Reform Act indicate that the plaintiff was intended to support his assertions at hearing. The statute itself refers to the evaluation of evidence by the
tribunal (see Appendix 1, line 7), defines “substantial evidence” and “admissible evidence” (Appendix 1, lines 33-41), and provides for the tribunal to subpoena witnesses and impartial experts in order to “substantiate or clarify” evidence before it (Appendix 1, lines 41-51). Such language does not accord with a legislative intent to foster decisions based on unsubstantiated representations by counsel.

Moreover, the fact sheets drawn up by the committee with jurisdiction over the act repeatedly liken the tribunal's finding to a determination of probable cause. According to the Massachusetts Supreme Court in Myers v. Commonwealth, 363 Mass. 847 (1973), a finding of probable cause is intended to “establish an effective bind-over standard which distinguishes between groundless or unsupported charges and meritorious prosecutions,” at 847, fn. 5, and must therefore be supported by evidence on each element of the crime charged. The Court continues to say that a “determination of probable cause to bind over is somewhat analogous in function to the trial court's ruling on a motion for directed verdict as to whether there is sufficient evidence to send the case to the jury.” At 848.

In the context of a tribunal hearing, application of a directed verdict standard would require that the plaintiff present evidence on each element of his claim (duty; breach of duty; injury; and causation), and that the evidence presented be substantial, i.e. “such evidence as a reasonable person might accept as adequate to support a conclusion.” (Appendix 1, lines 33-34). However, in accordance with the legislative intent that tribunal proceedings be streamlined and informal, the evidence presented by the plaintiff should not be required to be acceptable under the strict rules of evidence applicable at jury trial. In this way, a plaintiff with a good case would not be foreclosed at tribunal, but would be permitted to employ normal discovery proceedings to uncover admissible evidence with which he might ultimately prevail at trial.

While opponents of the directed verdict standard claim that it will result in undue hardship to plaintiffs, this need not be the case. A plaintiff should not burden the courts by bringing suit until he has thoroughly researched the merits of his claim. Under Massachusetts law, patients are permitted access to their medical records, and a
plaintiff may therefore search the record, undergo medical examinations by various experts, and interview witnesses prior to filing his complaint. If, in accordance with my recommendations, he is also granted limited access to discovery mechanisms before hearing, the plaintiff should not be hard pressed to meet a directed verdict test. The unusual instance in which plaintiff's counsel is unable to conduct preliminary investigations before the claim is foreclosed by the statute of limitations may be dealt with by permitting postponement or continuance of hearings on a showing of good cause.

Appeals

Issue: Should the plaintiff be permitted to appeal a decision against him or the imposition of an excessive bond?

Discussion: The legislation authorizing medical malpractice tribunals did not establish an appeals procedure from tribunal decisions. Yet, an unreasonable adverse finding, or the imposition of an excessive bond requirement at this stage may create an unwarranted but substantial impediment to further prosecution of the plaintiff's case.* Justice, therefore, demands that a plaintiff faced with either of these prospects be granted some recourse other than dismissal of his suit or compliance with the bond requirement.

According to the Massachusetts Supreme Court in Paro v. Longwood Hospital, 1977 Mass. 369 (1977), the tribunal procedure is part of the judicial process. One might reason, therefore, that a finding at tribunal would be subject to the same rights of appeal applicable in other court proceedings. If this is so, the plaintiff should be able to permit judgment to be entered against him and then appeal that judgment on the grounds that the tribunal decision was wrong as a matter of law (i.e. an inappropriate application of the directed verdict or other applicable standard to the plaintiff's presentation). He might also be permitted to appeal an excessive bond requirement in a similar fashion (after first moving for reduction of the bond in accordance with the statute), on the argument that the amount specified was beyond the appropriate limits of judicial discretion. Because interlocutory appeals are not permitted in Massachusetts, the defendant would be unable to appeal an unreasonable tribunal decision in favor of the

*Contrastingly, a finding against the defendant at tribunal merely subjects him to the usual judicial process, and does not foreclose him from the standard defenses or his right to a day in court.
plaintiff until after judgment is entered, or in other words, until after full trial on the merits.

While this appeals process may and should be available, none of the participants in tribunal proceedings is sure whether it is or not. The immediate problem, then, is not one of an inappropriate or controversial practice, but rather the existence of pervasive uncertainty over current procedure. Moreover, this uncertainty may not be resolved in the near future, as any plaintiff who ventures to file an appeal risks being thrown out of court and thus forfeiting all right to prosecute his claim.

Recommendation: No action need be taken at this time, beyond the continued observation of malpractice cases in order to discover whether or not appeals may be brought from tribunal decisions. Until the nature of the existing appeals procedure is resolved, there is little point in legislative amendment. While there is much uncertainty regarding the current state of affairs, few of the participants exhibit serious anxiety over that fact. In general, a plaintiff who feels strongly that the tribunal was wrong in finding against him will post bond and continue to trial. Few instances have arisen in which a plaintiff who wished to pursue his claim was unable to afford the bond ultimately required by the tribunal.

It should be noted, however, that at least one plaintiff has attempted to bring an appeal as suggested, and was successful in having the tribunal's decision overturned.* However, in the course of its four-line opinion, the Massachusetts Supreme Court explicitly declined to consider whether or not the plaintiff had standing to bring the appeal. Thus, although an encouraging precedent, the case is less than definitive on the crucial issue. More informative opinions, in future, might prove helpful to all concerned.

Admissibility of Tribunal Decisions at Trial

Issue: Should the decision of the tribunal, whether for the plaintiff or defendant, be admissible as evidence at subsequent trial?

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Discussion: While the enabling statute unequivocally states that "the decision of the tribunal shall be admissible as evidence at a trial," (see Appendix 1, lines 50-51), participants in the process are practically unanimous in denouncing this provision.

Recommendation: The decision of the tribunal should not be admissible as evidence at trial. Implementation of this recommendation will require legislative amendment, unless the practice in question is struck down as unconstitutional by the Supreme Court.

In general, the bond requirement is an adequate deterrent to prosecution of frivolous cases. Admitting the tribunal decision as evidence at trial will very likely result in unfair prejudice to the party losing at hearing. The issues addressed and evidence placed before a tribunal are vastly different from those presented to a jury. Jurors, however, may well be impressed by the composition of the tribunal and tend to ignore differences in the questions they considered. In order to combat this tendency and ensure a fair trial, it will be necessary for trial judges to issue forceful and perhaps detailed instructions describing the nature and function of malpractice tribunals, and specifying the appropriate weight to be given to tribunal decisions. This will consume valuable court time without promoting the objectives of the malpractice legislation or furthering the cause of justice.

As indicated in Appendix 3, the controversy over tribunal procedures extends far beyond the confines of the four major questions addressed above. However, constraints of time and space force me to curtail my discussion of the remaining issues. Accordingly, I have grouped them in order of their appearance in the process, and deal with them in a somewhat more summary fashion than might otherwise be desirable.

Selection of Tribunal Members. Although the statute specifies that the justice presiding at tribunal hearings should sit on the Superior Court, current practice is to appoint members of the District Court when the case backlog becomes excessive. Some of my sources complain that District Court judges are not as familiar with malpractice
law as are justices of the Superior Court, and argue that this practice should therefore be discontinued. I disagree. It comports with the underlying intent of the authorizing legislation to speed the disposition of malpractice cases, and I fail to see how it causes prejudice to either party. There is no reason to assume that the judges appointed will not familiarize themselves with applicable law to the best of their ability, and no basis for arguing that District Court judges are inherently less capable of comprehending malpractice law than, for example, judges newly appointed to the Superior Court.

The statutory restrictions on selection of the doctor member of the tribunal are, for the most part, unnecessary and burdensome. Since the doctor is required to represent the field of medicine in which the injury occurred, there is no good reason for the apparent additional requirement that he be a licensed surgeon (see Appendix 1, line 14). Similarly, since in practice (see Appendix 2), potential conflicts of interest are resolved in the scheduling process, there is no need for the somewhat illogical requirement that the doctor sitting on the tribunal not practice in the county where the defendant practices or resides. Removal of these restrictions would entail a legislative amendment, but would considerably alleviate current scheduling difficulties.

According to the authorizing legislation, “[w]here the action of malpractice is brought against a provider of health care not a physician, the physician’s position on the tribunal shall be replaced by a representative of that field of medicine in which the alleged tort or breach of contract occurred, as selected by the superior court justice in a manner he deems fair and equitable.” (See Appendix 1, lines 23-27) This paragraph is currently being interpreted to require that cases brought against a hospital be heard by a hospital administrator. However, as administrators are not necessarily versed in medicine, they are frequently unable to provide the expert input into a tribunal decision which was apparently intended by the legislature in placing a health care representative on the panel. Since a hospital does not constitute a “field of medicine,” it would seem to be within the meaning of this provision to permit selection of a doctor rather than a hospital administrator whenever the medical issues in such a case threaten to be particularly complex. A court ruling to this effect would promote the
effectiveness of malpractice tribunals as screening bodies; and, because the health care field would still be represented on the panel, and the interests of the defendant would be protected through the presence of its counsel at hearing, such a ruling would not result in any prejudice to the defendant hospital.

My sources have indicated that justices presiding at tribunal occasionally designate more than one doctor to sit on a panel when a case involves various defendants of diverse medical specialties. Each doctor sits solely with regard to the defendant in his field, so that, in essence, that proceeding consists of several separate tribunals with overlapping memberships sitting simultaneously. The statute makes no explicit provision for this procedure, only stating that “[w]here there are codefendants representing more than one field of health care the superior court justice shall determine in his discretion who [no number specified] shall represent the health care field on the tribunal,” (Appendix 1, lines 28-30, emphasis and commentary supplied). I see no policy grounds on which this practice should be curtailed. Rather, it seems to be a logical and efficient response to a complex situation, permitting the tribunal to address all relevant medical issues at one time with an informed mind.

Scheduling of the Hearing. The statutory requirement that hearings be held within 5 days after the defendant files his answer is both completely unrealistic and universally ignored. The process of scheduling a tribunal (see Appendix 2) can rarely if ever, be accomplished within 5 days. Rather, hearings are generally held any time up to 4 or 5 months after the pleadings come in. Should the legislature desire to bring the law into line with the practicalities of the situation (and simultaneously authorize sufficient time for the plaintiff to conduct pre-hearing discovery when necessary, as recommended above), it could adopt either of two possible amendments to the statute. On the one hand, it could require that tribunals be scheduled within, say, 60 day after the last answer is filed, except on timely showing of good cause. On the other hand, it could provide that hearings be held within a reasonable period of time, to be determined at the discretion of the presiding justice. The first alternative would place greater symbolic emphasis on the legislative intent that frivolous cases be weeded out
early in proceedings. However, in practice, little would be lost by adopting the second alternative. As the current situation illustrates, it is next to impossible to enforce scheduling requirements without the active cooperation of the judicial branch. Moreover, since malpractice litigation rarely reaches trial until well over a year after pleadings are filed, the process would scarcely be delayed by permitting tribunals to be scheduled at the convenience of all concerned.

Conduct of the Hearing and Deliberation by the Tribunal. Hearings should generally be fairly short (approximately an hour), informal proceedings in which all participants are permitted to comment on the case and present relevant evidence. In the interest of increasing speed and reducing costs, the current practice of avoiding oral testimony in all but the most unusual circumstances should be continued. This is particularly so with regard to experts subpoenaed by the tribunal, for as long as their testimony is made admissible at subsequent trial (see Appendix 1, lines 51-52), justice requires that they be subject to cross-examination by all parties at hearing. All written evidence described in Appendices 1 and 2 should be admissible, including depositions, but submissions should either be brief or else be summarized and indexed for easy reference to pertinent points. The plaintiff should be permitted at least 20 minutes of oral argument, and should be required (as recommended above in the section on standard of proof) to present substantial evidence ("such evidence as a reasonable person might accept as adequate to support a conclusion") on each element of his claim in order to prevail. The defendant should be permitted to submit evidence as well, and also to make a brief oral statement on the sufficiency of the plaintiff's case and the nature of his submissions. Defendant's comments and evidence, however, should properly be directed to gaps and inconsistencies in the plaintiff's offer of proof. Evidence on disputed questions of fact (such as the appropriate standard of care and the competence and credibility of plaintiff's witnesses), unless rising to the level of legal significance, is irrelevant to the issue before the tribunal, which relates solely to the sufficiency of the plaintiff's case, and not to the adequacy of the defense. The tribunals were
intended to eliminate *frivolous* suits, not to dispose of plausible suits on the merits. To the extent that these suggestions are susceptible to enforcement, they may be implemented by rule of court and do not require legislative action.

Because the doctor was presumably placed on the tribunal to provide an impartial expert assessment of the evidence and issues, he should be permitted to comment on general medical practice as well as on the particular features of the plaintiff's case. However, in order to ensure that his comments and opinions respond to the precise question facing the tribunal, he should be instructed by the judge, in open court, on the nature of the applicable standard of proof. For, it is a very different question whether, as might be asked by an uninstructed doctor, the plaintiff's presentation clearly proves he was a victim of medical malpractice; or whether, as must be asked by members of a tribunal in accordance with the directed verdict standard, his evidence is such that, if *evaluated in the light most favorable to his case*, it would support a *reasonable man* in concluding that his injury resulted from medical malpractice. The parties have a legitimate interest in knowing that the doctor is aware of this difference, and that he, along with the rest of the panel, is applying the appropriate standard. Similarly, it is only fair to the participants, although clearly impossible to enforce, that the doctor's comments be made in open court and on the record. These requirements of judicial instruction and open procedure may be promulgated by rule of court.

Some fairly serious controversy exists over the weight which should be given to the doctor's opinion (1) when it contradicts written testimony (affidavits, depositions, letters) provided by the plaintiff; and (2) when it fills in one or more gaps in the plaintiff's offer of proof. My feeling is that any substantial evidence presented by the plaintiff on an issue susceptible to debate must be viewed as raising a "legitimate question of liability appropriate for judicial inquiry," and should therefore not be weighed against other evidence, even when that evidence comes from an impartial source. With respect to the second issue, I feel that the doctor's opinion should be permitted to substantiate a plaintiff's claim. I recognize that this practice would permit a plaintiff to prevail at tribunal even though he, personally, did not
present evidence on all elements of his claim, and that it would therefore represent a technical deviation from application of the directed verdict (evidence-on-all-elements) requirement solely to the contents of plaintiff's offer of proof. Nevertheless, for a tribunal to find against a plaintiff despite knowledge of evidence sufficient to substantiate his case would constitute an intolerable perversion of justice and should not be allowed. As far as I am able to ascertain, however, there is no need to take any specific action on either of these points, even though they are highly controversial.* Most tribunals will not be unduly swayed by the doctor's opinion when it is in opposition to the plaintiff's claims, but will accept his assessment when it supports that claim, on the theory that, if he errs at all, the doctor will err in favor of his profession.

The Finding. Consistent with my position on the proper weight to be attached to the doctor's medical opinion of a plaintiff's claim, I feel that the tribunal should be permitted to find in favor of the plaintiff by majority vote but should not be permitted to find against him by other than unanimous vote. This disparity of treatment may be justified by reference to the fact that, under a directed verdict test, the evidence is to be regarded in the light most favorable to the plaintiff. If one member of an impartial tribunal reviewing the plaintiff's offer of proof feels it presents a legitimate question of liability appropriate for judicial inquiry, dissenting members cannot, strictly speaking, be viewing the evidence in the light most favorable to the plaintiff. The countervailing argument, of course, is that each member of the tribunal casts his vote in accordance with the most-favorable-light criterion, and therefore proper deference to the plaintiff's case is factored into the finding before the vote is cast. To require a unanimous vote permits a greater number of potentially frivolous (as well as potentially meritorious) claims to pass through the screening process. At present, practice on this issue varies from tribunal to tribunal. Some require a unanimous vote in all instances, while others permit a finding by majority. None that I know of have adopted a split decision rule, permitting majority votes in favor of the plaintiff, but insisting on unanimous votes in favor

*Not surprisingly, the loudest complaints on this practice come from counsel for the defendant.
of the defendant. Implementation of this particular practice might well require legislative amendment. However, a decision to require either unanimous or majority votes in all cases, across all tribunals (which would at least alleviate the unfairness of the present variation in practice) could definitely be implemented by rule of court.

In issuing its decision, I would argue that the tribunal should be as terse as possible, ideally going only so far as to indicate whether or not the plaintiff presented sufficient evidence to raise a legitimate question of judicial inquiry. Supporting reasons would make the finding unnecessarily complex, while tending, if the case ultimately goes to trial and the tribunal's decision is admitted as evidence, to prejudice the losing party to a greater extent than an unadorned recital. I would also argue that the vote should not be revealed on the finding, so that jurors at subsequent trial are not unduly drawn into the question of intrapanel dynamics, and hence overly impressed with the importance of the tribunal's decision for the proper resolution of the issues before them. These recommendations, however, are qualified by recognition of the fact that failure to indicate supporting reasons or the existence of a dissenting opinion may deny counsel valuable information on the strength of their client's case. This counterpoint could be resolved by a legislative amendment forbidding the admission of the finding as evidence at subsequent trial, for there would then be no need to protect the jury from overexposure to any aspect of the tribunal's decision.

The Bond. The statutory language authorizing a bond requirement reflects two purposes: the deterrence of frivolous suits; and the compensation of defendants who are forced to litigate nonmeritorious claims despite a finding in their favor at tribunal. Accordingly, I recommend that the current practice of requiring plaintiff to post a separate bond for each defendant with respect to whom the tribunal finds against him be continued. Although seemingly harsh to the plaintiff, it does operate to reduce the unwarranted costs of defending suits essentially brought against the wrong group of people, and will hopefully result in lower costs for health care. Whether or not it achieves this goal, however, this procedure manifestly furthers the statutory intention of streamlining malpractice litigation by paring down those cases in which a plaintiff sues almost everyone in the hospital where the alleged malpractice took place.
At the same time, I recommend against requiring a separate bond for each count of a plaintiff's claim against a single defendant. This procedure results in over-deterrence of the plaintiff without furthering the defendant's legitimate interest in compensation for unnecessary expenses. Despite the presentation of different theories of recovery, plaintiff's claim relates to a single face pattern. Thus, preparation of appropriate defenses involves substantial overlap, particularly since the rules of civil procedure permit a judgment in favor of the plaintiff if he is so entitled, regardless of whether or not he set forth the proper theory in his pleadings. M.R.C.P. 54(c).

In determining how much the plaintiff must post in order to proceed to trial, the presiding justice should take into account the merits of the case and the financial resources of the plaintiff. However, in my opinion it is not appropriate for either the initial justice or another justice presiding over a motion to reduce bond on grounds of indigency to question the defendant as to whether or not he is insured. While defense of a nonmeritorious suit would have a greater effect on the personal finances of an uninsured physician than of an insured physician, the primary purpose of the Malpractice Reform Act was to lower the operating costs of the malpractice insurance industry. Therefore, bond should not be reduced in cases against insured doctors where it would not be reduced were the defendant uninsured.

Dismissal Procedure. As indicated in Appendix 2, absent a stipulation by the plaintiff to dismissal of the suit, a case will not be dismissed after a finding against the plaintiff until the defendant so moves and his motion is granted by the justice presiding at the motions session. This practice is time-consuming and burdensome both to the defendant, who must bring the motion, and to the courts, which must hear it. Automatic dismissal of plaintiff's suit after 30 days have passed from entry of an adverse finding on the docket without compliance or motion by the plaintiff would further the interests of efficiency and economy. Such a procedure seems to fall within the contemplation of the statute, which merely provided that "[i]f said bond is not posted within thirty days of the tribunal's finding the action shall be dismissed." (See Appendix 1, lines 59-60). Accordingly, it could be instituted by rule of court.
Subsequent Trial. As argued above, the decision of the tribunal should not be admissible at trial. However, if the legislature fails to adopt this recommendation, the resulting prejudice to the party losing at tribunal should be minimized by issuance of appropriate instructions to the jury. Specifically, the tribunal's decision should be given no special weight as evidence in the course of jury deliberations, and they should be told that the statute does not endow the finding with any compelling legal force. Again, the rationale for this extreme caution lies in the differing procedures employed, issues addressed and evidence presented at hearing as opposed to trial on the merits. I am not convinced, however, that any action need be taken of this issue. Counsel are likely to submit suggested instructions conforming to my recommendation, and the proper contents of these instructions should be promptly resolved on appeal.*

Like the finding of the tribunal, the testimony of expert witnesses subpoenaed at hearing should not be admissible as evidence at trial. This suggestion may be relaxed if the expert was subject to cross-examination by all parties before the tribunal. However, permission of cross-examination would considerably lengthen the hearing stage, and thereby thwart the intention of the legislature to devise a speedy and informal screening process. The better course would be for the legislature to amend the statute so as to prohibit admission of testimony taken at tribunal as evidence at trial.

If the plaintiff's presentation at trial differs significantly from the contents of his offer of proof, defendant should of course be permitted to submit transcripts of the hearing in order to point out these deviations. The danger of serious departures, however, can be minimized by adoption of the directed verdict standard in place of the unsubstantiated offer of proof at the tribunal stage. Deviations which approach the level of deceit might be dealt with by disciplinary action against the offending attorney; however, such matters fall outside the proper scope of this memorandum.

COMMENTS

At the present time, the medical malpractice tribunal system oper-

*Not, however, necessarily in accordance with my remarks.
ates mainly to the advantage of the defendant, in accordance with the legislature's justifiable concern over the price and availability of medical care in Massachusetts. However, the Special Commission on Medical Malpractice has also affirmed its interest in promoting high quality medical care throughout the Commonwealth. The tort system functions on the premise that incorporation of the cost of fault-based mistakes into the operating costs of practitioners, by way of malpractice suits, acts to improve the quality of care available in the jurisdiction by encouraging preventive measures and constant vigilance. Thus, not only is it important that defendants be spared the anxiety and cost associated with defending frivolous claims; it is also important that plaintiffs not be deterred in the pursuit of rightful awards by unnecessarily high costs of litigation — which may be, and frequently are, compounded by unwarranted delaying actions on the part of the defense. Unfortunately, reorientation of the tribunal procedure to require, for example, that proponents of frivolous defenses postpone before proceeding to trial or, alternatively, be assessed costs on losing at trial after an adverse finding by tribunal, would be completely impractical. The tribunal would be forced to hear far more evidence from both parties, and weigh the evidence for either side; in effect, the hearing would become a minitrial. Other remedial actions, however, have greater potential. Counsel for insurance companies, for instance, have a policy against making settlement offers prior to the first day of trial. This policy could be attacked outright or subtly undermined by requirements that both parties negotiate in good faith prior to the date of trial, with various penalties being attached to provable instances of bad faith. Or, the screening approach could be discarded, and a compulsory arbitration procedure instituted in its place, at least with respect to certain types of claims.
APPENDIX 1:
Authorizing Legislation for Medical Malpractice Tribunals
M.G.L.A. c. 231, section 60B

60B. Malpractice action against provider of health care; tribunal; composition, etc.; evidence; witnesses; findings; expenses.

Every action for malpractice, error or mistake against a provider of health care shall be heard by a tribunal consisting of a single justice of the superior court, a physician licensed to practice medicine in the commonwealth under the provisions of section two of chapter one hundred and twelve and an attorney authorized to practice law in the commonwealth, at which hearing the plaintiff shall present an offer of proof and said tribunal shall determine if the evidence presented, 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.

Said physician shall be selected by the single justice from a list submitted by the Massachusetts Medical Society representing the field of medicine in which the alleged injury occurred and licensed to practice medicine and surgery in the commonwealth under the provisions of section two of chapter one hundred and twelve. The list submitted to the single justice shall consist only of physicians who practice medicine outside the county where the defendant practices or resides or if the defendant is a medical institution or facility outside the county where said institution or facility is located. The attorney shall be selected by the single justice from a list submitted by the Massachusetts Bar Association. The attorney and physician shall, subject to appropriation, each be compensated in the amount of fifty dollars.

Where the action of malpractice is brought against a provider of health care not a physician, the physician's position on the tribunal shall be replaced by a representative of that field of medicine in which the alleged tort or breach of contract occurred, as selected by the superior court justice in a manner he determines fair and equitable.

Where there are codefendants representing more than one field of health care the superior court justice shall determine in his discretion who shall represent the health care field on the tribunal.
Each such action for malpractice shall be heard by said tribunal within fifteen days after the defendant's answer has been filed. Substantial evidence shall mean such evidence as a reasonable person might accept as adequate to support a conclusion. Admissible evidence shall include but not be limited to, hospital and medical records, nurses' notes, x-rays and other records kept in the usual course of the practice of the health care provider without the necessity for other identification or authentication, statements of fact or opinion on a subject contained in a published treatise, periodical, book or pamphlet or statements by experts without the necessity of such experts appearing at said hearing. The tribunal may, upon the application of either party or upon its own decision, summon or subpoena any such records or individuals to substantiate or clarify any evidence which has been presented before it and may appoint an impartial and qualified physician or surgeon or other related professional person or expert to conduct any necessary professional or expert examination of the claimant or relevant evidentiary matter and to report or to testify as a witness thereto. Such a witness shall be allowed traveling expenses and a reasonable fee to be fixed by the tribunal which shall be assessed as costs. The testimony of said witness and the decision of the tribunal shall be admissible as evidence at a trial.

If a finding is made for the defendant the plaintiff may pursue the claim through the usual judicial process only upon filing bond in the amount of two thousand dollars secured by cash or its equivalent with the clerk of the court in which the case is pending, payable to the defendant for costs assessed, including witness and experts' fees and attorneys' fees if the plaintiff does not prevail in the final judgment. Said single justice may, within his discretion, increase the amount of the bond required to be filed. If said bond is not posted within thirty days of the tribunal's finding the action shall be dismissed. Upon motion filed by the plaintiff, and a determination by the court that the plaintiff is indigent said justice may reduce the amount of the bond but may not eliminate the requirement thereof.

For the purpose of this section, a provider of health care shall mean a person, corporation, facility or institution licensed by the commonwealth to provide health care or professional services as a physician, hospital, clinic or nursing home, dentist, registered or licensed nurse,
optometrist, podiatrist, chiropractor, physical therapist or psychologist, or an officer, employee or agent thereof acting in the course and scope of his employment. The expenses and compensation of said tribunal shall be paid by the commonwealth, provided, however, that the pro rata percentage of such expenses and compensation engendered by actions brought against providers of health care registered under chapter one hundred and twelve shall not be in excess of the amounts received by the commonwealth for registration fees for such providers of health care under said chapter one hundred and twelve, less the amount expended for expenses and compensation of the respective boards of registration of said providers of health care under said chapter one hundred and twelve.

Added by St. 1975, c.362, Section 5.
APPENDIX 2: Progress of Typical Tribunal Proceedings.

Initiation of Proceedings. The tribunal procedure starts when a complaint is filed with the Superior Court in a particular county, and the court clerk determines that it raises a question of medical malpractice. The clerk notifies the Office of the Chief Justice of the Superior Court that a malpractice case has come in. As soon as the defendant files an answer, copies of both pleadings are sent to the Chief Justice. He then designates one of his associates (or a District Court judge) to preside at the tribunal, notifies him of the assignment, and sends him a copy of the pleadings. From this point on, the Office of the Chief Justice regards the progress of the tribunal as the responsibility of the designated justice.

Selection and Scheduling of the Tribunal. While in some counties the designated justice does take personal responsibility for securing a doctor and an attorney to serve on the tribunal, as well as for scheduling the hearing, this is not a uniform practice. In Middlesex County, where a great number of malpractice tribunals are held, all are arranged by a single individual in the office of the court clerk. He selects a doctor in the relevant medical specialty from a list provided by the Massachusetts Medical Society, and tentatively schedules the hearing at the doctor's convenience, on the theory that his hours are less flexible than those of the other participants. He then notifies all concerned of this time and of the doctor's identity, resolving any scheduling problems and making sure there is no conflict of interest created by this selection. Once he has determined that both the time and doctor are satisfactory to everyone, he contacts attorneys from a list provided by the Massachusetts Bar Association, choosing one for whom the scheduled hearing time is convenient. He then repeats the consultation process followed with respect to the doctor, and if no conflict is discovered, notifies all participants of the final arrangements. This procedure varies from that followed in Suffolk County, where the responsibility for selecting a doctor and an attorney to serve on the tribunal rests with two different clerks who operate independ-
ently of one another. Despite these inter-county variations in procedure, all participants seem content with the selection and scheduling mechanisms. According to my sources, those in charge of these matters are generally careful to accommodate all parties, and are prepared to provide sufficient advance warning of the identity of the tribunal members to permit the discovery and subsequent elimination of any potential conflict of interest problems.

Conduct of the Hearing. All tribunal hearings are recorded by an official court stenographer and are open to the public. Nevertheless, the actual parties rarely choose to attend, making the proceedings almost exclusively a lawyers’ affair.

At the outset of the hearing, counsel for the plaintiff presents the tribunal with three copies of any written material he has prepared as part of his offer of proof. These may include a brief on the facts and law of the case, photographs of the injury, medical records, affidavits, and copies of relevant medical texts. While some judges do permit the plaintiff to introduce depositions as evidence at a tribunal hearing, others do not; and even those who do may be willing to grant a defendant’s motion, made prior to the hearing, to bar all discovery by the plaintiff until after the tribunal has handed down its decision.

The members of the tribunal then scan the plaintiff’s submissions, following which counsel for the plaintiff is permitted to present a brief oral summation (ranging roughly from 5 to 30 minutes in length, depending on the complexity of the case and the identity of the presiding justice) of the facts and law of his client’s suit. The tribunal may interrupt him from time to time in order to clarify various points. After he has concluded his presentation, counsel for the defendant is generally permitted to address the tribunal. According to my observations, he is often allowed to submit written material, including briefs of fact and law, medical records, and affidavits. However, this practice is not universal, and in some instances the defendant’s lawyer is confined to commenting on the sufficiency of the plaintiff’s offer of proof. Like the plaintiff’s attorney, he may be questioned by the tribunal. If counsel for the plaintiff requests it, the tribunal may grant him a short period in which to rebut the arguments raised for the defendant.
Although the enabling legislation explicitly authorizes the tribunal to summon witnesses (see Appendix I, lines 46-55), the actual practice is to avoid oral testimony in all but the most unusual cases. If there are clear gaps in the plaintiff's offer of proof, he may be granted a continuance to permit him to buttress his presentation. However, this seems to be a relatively rare event.

Deliberation by the Tribunal. Once all parties have finished their presentations, the tribunal adjourns to deliberate. In general, tribunals seem to rely primarily on the oral summations by counsel, supplemented by the doctor member's opinion of the medical practice and result in question. Only occasionally do they review in detail the written material submitted by the parties.

In the course of their deliberations, tribunals presided over by different justices employ different decision rules, or standards of proof. Some require that the plaintiff submit enough evidence on each element of his case (duty; breach of duty; injury; proximate cause) to avoid a motion for directed verdict if the case were at trial. This is called the directed verdict standard. Some will accept the plaintiff's assertions that such evidence will be provided at trial. This practice comports with the traditional connotations of the term, "offer of proof". In other cases, it is unclear what standard, if any, forms the basis for a tribunal's decision for or against a plaintiff.

The Finding. Once the tribunal reaches a decision, it prepares a finding, notifies counsel for both plaintiff and defendant of the result, and forwards the finding to the court clerk for entry on the docket.

If the finding is for the plaintiff, it generally reads that "the evidence presented, if properly substantiated at trial, is sufficient to raise a legitimate question of liability appropriate for judicial inquiry." A finding for the defendant, however, may read either that "the evidence presented, if properly substantiated at trial, is not sufficient to raise a legitimate question of liability appropriate for judicial inquiry," (emphasis supplied) or that "the plaintiff's case is merely an unfortunate medical result." It will also state the amount of the bond imposed on the plaintiff as a prerequisite to further proceedings. While a decision for either plaintiff or defendant may be by majority only, the finding will normally indicate neither the vote nor the reasoning behind it.
Subsequent Proceedings. If the tribunal finds for the plaintiff, the case proceeds to trial in the usual fashion, with the tribunal’s decision admissible as evidence at the trial.

If the tribunal finds for the defendant, the plaintiff may want to drop the case completely. He may do this either by stipulating to its dismissal, or by failing to post the required bond within the allotted time period. Absent a stipulation, the case will not be dismissed until the defendant has moved for its dismissal and his motion has been granted by the justice presiding at the motions session.

Should the plaintiff wish to pursue his claim despite an adverse finding by the tribunal, he may post bond in the stated amount (usually $2,000), payable to the defendant for costs assessed if the defendant wins at trial. Or, if the plaintiff cannot afford the specified sum, he may move to have it reduced on the grounds of indigency, and his motion will be heard by the justice presiding at the motions session. If he prevails, he may post bond in the reduced amount and proceed to trial of the case. Again, the decision of the tribunal is admissible at the trial.

If a plaintiff is unable or unwilling to post any bond, and feels the tribunal did not apply the appropriate standard in finding against him, it may be possible for him to appeal the decision. To do so, however, he must first permit the defendant to have the case dismissed for failure to post bond, and then allow judgment to be entered against him. If the appellate court either rules against him on the merits, or finds that he has no standing to bring the appeal (this issue is currently unresolved), the plaintiff has no further judicial recourse.

If the case proceeds beyond the tribunal stage, and the plaintiff subsequently adds one or more defendants to the suit, they are permitted a tribunal hearing on their liability for his injury. The result of this hearing, however, does not affect the viability of the plaintiff’s claims against the original named defendant(s).
Various aspects of the malpractice tribunals remain controversial despite two years of experience with the system. The following questions, which progress in a roughly chronological fashion through the tribunal procedure, suggest the nature and contours of existing confusion and discontent.

Prior proceedings
1. How much, if any, discovery should be permitted prior to the hearing? Under what circumstances?

Selection of Tribunal Members
2. Should the Chief Justice be permitted to designate District Court judges to preside over malpractice tribunals?
3. Is there any valid reason for the apparent requirement (see Appendix 1, line 14) that the doctor sitting on the tribunal be a surgeon, or for the provision (Appendix 1, lines 17-19) that he must practice outside the county in which the defendant practices or resides?
4. In cases in which the defendant is a hospital, but the injury complained of is medically complex, may the presiding justice select a doctor rather than a hospital administrator to represent the health care field on the tribunal?
5. Should the presiding justice be permitted to select more than one representative of the health care field to sit on tribunals in cases in which there are multiple defendants from different medical specialties?

Scheduling of the Hearing
6. How quickly should the tribunal be held, given that the 15-day period provided by law (see Appendix 1, line 32) is universally condemned as unrealistic?

Conduct of the Hearing
7. What sort of presentation should the plaintiff be permitted to make?
8. What sort of presentation should the defendant be permitted to make? Should he be allowed to comment on the credibility, as opposed to the sufficiency, of the plaintiff's offer of proof?

9. What is the proper role of the doctor sitting on the tribunal? May he testify regarding general medical practice or comment on particular features of a plaintiff's case?

10. Should the presiding justice announce the standard of proof which will be used by the tribunal in its deliberations?

11. Under what, if any, conditions should the tribunal grant a continuance to either party?

12. If a tribunal subpoenas an expert witness to testify at the hearing (see Appendix 1, lines 41-51), should he be subject to cross-examination by all parties?

_Deliberation by the Tribunal_

13. What standard of proof should the plaintiff be required to meet in order to prevail at a hearing?

14. May the tribunal disregard opinion evidence provided by the plaintiff in his offer of proof? May it supplement an inadequate presentation with the privately expressed opinion of the doctor member?

_The Finding_

15. Should the tribunal be permitted to find against the plaintiff by majority vote?

16. Should the finding reveal the vote and delineate the rationale supporting the tribunal's decision?

_The Bond_

17. Should a plaintiff who loses at the tribunal stage be required to post a separate bond for each defendant before proceeding to trial?

18. When the plaintiff's complaint raises several counts against a single defendant, should the bond requirement apply to each count, or only to the case as a whole?

19. Is it proper for the tribunal to consider whether or not the defendant doctor is insured in determining how much the plaintiff must post in order to proceed to trial?
**Dismissal Procedure**

20. If a bond is required and the plaintiff fails to act within the specified time period, should the case be dismissed automatically, or should the defendant be required to move for its dismissal before judgment will be entered in his favor?

**Appeals**

21. Should the plaintiff be permitted to appeal a finding against him?

22. Should the plaintiff be permitted to appeal the imposition of an excessive bond?

**Subsequent Trial**

23. Should the decision of the tribunal be admissible as evidence at trial? If so, what weight should it be given?

24. Should the testimony of an expert witness subpoenaed by the tribunal be admissible as evidence at trial?

25. Should the defendant have any recourse if the plaintiff's presentation at trial differs significantly from the contents of his offer of proof?
AN ACT EXTENDING THE MEDICAL MALPRACTICE INSURANCE JOINT UNDERWRITING ASSOCIATION.

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

1. Section 13 of Chapter 362 of the Acts of 1975, as most recently amended by Chapter 474 of the Acts of 1977, is hereby amended by striking out in the second sentence the words: “December thirty-first, nineteen hundred and seventy-nine” and inserting in place thereof the following words: “December thirty-first, nineteen hundred and eighty-one”.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Seventy-Nine.
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 second paragraph the first and second sentences and inserting in place thereof the following sentence:

Said physician shall be selected by the single justice from a list submitted by the Massachusetts Medical Society representing the field of medicine in which the alleged injury occurred and licensed to practice medicine in the commonwealth under the provisions of section two of Chapter one hundred and twelve.

SECTION 2. Section 60B is further amended by striking out the fifth paragraph and inserting in place thereof the following paragraph:

Each such action for malpractice shall be heard by said tribunal within sixty days after the defendant's answer has been filed. Substantial evidence shall mean to give such evidence as a reasonable person might accept as adequate to support a conclusion. Admissible evidence shall include, but not be limited to, hospital and medical records, nurses' notes, x-rays and other records kept in the usual course of the practice of the health care provider without the necessity for other identification or authentication, statements of fact or opinion on a subject contained in a published treatise, periodical, book or pamphlet or statements by experts without the
necessity of such experts appearing at said hearing. The tribunal may upon the application of either party or upon its own decision summon or subpoena any such records or individuals to substantiate or clarify any evidence which has been presented before it and may appoint an impartial and qualified physician or surgeon or other related professional person or expert to conduct any necessary professional or expert examination of the claimant or relevant evidentiary matter and to report or testify as a witness thereto. Such a witness shall be allowed traveling expenses and a reasonable fee to be fixed by the tribunal which shall be assessed as costs. The testimony of said witness shall not be admissible as evidence at a trial except for impeachment purposes. The decision of the tribunal shall be admissible as evidence at a trial.