

A Medical Malpractice Tribunal Experience

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Physicians in the United States have serious concerns about the exorbitant cost of medical liability insurance. The expense continues to have a major impact on physician practice patterns and access to medical services in many communities. More than 30 years ago, difficulty in obtaining adequate and affordable medical liability coverage generated new legislative initiatives in many states, including Massachusetts. These laws represented attempts to discourage potential plaintiffs from bringing frivolous malpractice claims and thus to limit the resultant professional and personal costs for the physician and expenses for the insurance companies.

In Massachusetts, the legislature established a Medical Malpractice Tribunal, consisting of a single justice of the Superior Court, an attorney authorized to practice law in the Commonwealth and selected sequentially from a list compiled by the court, and a physician licensed to practice in the Commonwealth.^{1–3} On several occasions, I have served as the physician member of the Tribunal. This experience has provided me a first-hand look at one mechanism for addressing the malpractice insurance crisis. The scope of the Tribunal was limited to concerns regarding medical treatments and the professional conduct of physicians and medical institutions or facilities and covered any liability action in any county in the state.

The standard of law for the Tribunal is to:

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... 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. . . . [S]ubstantial evidence is that which a reasonable person might accept as adequate to support a conclusion.¹

Additional powers of the Tribunal include subpoena powers for any records or individuals in an effort to clarify the evidence presented. Other professional experts may be appointed to provide examinations of the claimant or other "evidentiary matter and to report or to testify as a witness thereto."¹ The attorney and physician members receive \$50.00 per day compensation, depending on the state's available appropriation allotment.

The Hearing Procedure

Once the defendant is served with a complaint, the physician, medical institution, or facility may file a request to convene a Medical Malpractice Tribunal with an answer to the plaintiff's claim. The statute requires that the action for malpractice be heard within 15 days following the filing of the defendant's answer. Evidence admissible during the hearings may include hospital and medical records, nurses' notes, x-rays, and other appropriate medical documentation and statements of fact or opinion on a subject, which may be in published documents, in-person statements, or written statements of experts.

A case alleging medical malpractice may move forward to trial with the concurrence of the Tribunal's findings of its merit regarding the facts of the case. In those matters in which the Tribunal does not concur with the facts as presented by the plaintiff, a cash bond of \$6,000 must be posted before the case may

proceed through the usual judicial process. Another provision of this law provides that the Tribunal can reduce the amount of the required bond if the plaintiff is indigent.

Many states now utilize a variety of methods, such as proactive legislation, to cap the amounts of plaintiff awards, govern mediation, and determine the form of the physician's apology as integral parts of action plans to address liability reform.³⁻⁷ The Medical Malpractice Tribunal continues as a cornerstone of the current malpractice litigation process in Massachusetts. Although there have been challenges through the years, this law remains in place, albeit with clarifications provided by the Massachusetts Supreme Judicial Court concerning the intent and powers of the tribunal system.

The Tribunal Experience

Physician members of the Tribunals are selected from a pool of members of the Massachusetts Medical Society who volunteer for this service. They must be certified in the medical area of practice of the defendant physician and/or health entity that will be considered during the hearings. The sole exclusion is that the physician member may not work or live in the same county as the defendant physician. In one case, I was able to identify another potential area of conflict and I notified the screening administrator. In this particular case, I had been involved some years earlier in the clinical assessment of one of the parties and had been a member of the department of one of the defendants. I disqualified myself from participating. This information was presented by the administrator to the plaintiff who asked that I remain on the panel. I did not.

In preparing for the work of the Tribunal, I sought to identify other medical colleagues who had participated. These physicians viewed their involvement as providing a useful service to the profession of medicine. I was not able to identify other psychiatrist members before my appearance, but physicians practicing in the surgical specialties were enthusiastic about the process and encouraged my participation.

The Tribunal must apply a standard of review comparable to that applied to a defendant's motion for a directed verdict and refrain from appraising the weight and credibility of the evidence.⁸ A defense motion for a directed verdict will be granted only when, after presenting all the evidence most favorable to the plaintiff, the court finds insufficient evidence to support a

verdict in the plaintiff's favor.⁸ All of the cases heard during my service were considered to have merit and were not dismissed.

The plaintiff is required to show an offer of proof at the hearing. The proof may include expert opinions regarding the merits of the case: medical records, including, when applicable, reports of the medical examiner; testimony from police officials; and affidavits of other parties identified as possessing evidence pertinent to the hearing. These materials and all arguments to be presented by the plaintiff, physician, and/or medical facility must be sent to the Tribunal at least two weeks in advance of the hearing date. In practice, the material arrived early in most instances.

The length of the documentation received by the Tribunal varied significantly, from 13 double-spaced pages to 400 single-spaced pages. The length depended on the amount of medical information and number and length of hospitalizations, as well as the reports of other medical professionals involved. In one case, I looked at the large box of material that I had received and revisited my decision to participate in the process. Earlier, when I had agreed to participate, it had seemed a worthwhile new experience, and there had been open time in my schedule. However, when the material arrived, I was in a different place in my time management.

I hoped that some explanatory information would help me to prepare for the hearing process. A call to the administrator revealed that there was no orientation, but that instructions would be provided by the judge. I wondered if I would be asked about the details of the latest theories regarding the medical information to be presented. While the latter was a possibility, it was not based on reality. It was more a measure of my anxiety about sitting "on the bench." A significant impediment to my best intentions to be prepared and to provide the most complete review of the material was the illegibility of the medical record. The handwritten records appeared to be incomplete and written in the shorthand and special syntax of the physician. No matter how many ways I positioned the record, I was unable to decipher a complete record of the psychiatric treatment. Another call to the court administrator assured me that this concern would be addressed by the judge at the hearing. As it turned out, the other members looked to me first for my interpretations of the medical record and, in particular, that part of the record that I could not read. During my experience, the Tribunal heard between

two and four cases in one session. The hearings moved quickly, but the time seemed adequate to hear the cases.

The Tribunal members sit on the bench and hear the cases in an open courtroom. The attorneys representing the parties present their cases, generally without witnesses, but witnesses are permitted by statute. In a few cases, there may be multiple defendants, each represented by an attorney. If the health care entity and a physician employee are named, it is likely that each will be represented by separate counsel. During the course of sitting as a Tribunal member, the cases that I heard represented different allegations of malpractice. The scope of the claims included those areas that are common in malpractice litigation throughout the country, such as deviation from the standard of care by failure to diagnose and treat properly, improper prescribing practices, failure to maintain appropriate medical records, failure to provide appropriate training to staff, failure to follow appropriate medical oversight with respect to seclusion and restraint, and failure to maintain appropriate professional boundaries in the patient-doctor relationship.^{9,10} All of these cases related to some aspect of psychiatric practice, and none was of a frivolous nature.

The members by statute are permitted to ask questions of the plaintiff and defendant. In one case, I asked for further information regarding a breach of professional boundaries that was alleged in the plaintiff's presentation. However, in practice, the defense attorneys quickly deflected these inquiries with challenges regarding the statutory authority of the Tribunal and suggested that the questions were more appropriate for a trial court.

It is my impression that plaintiff and defense attorneys anticipate that the hearing process is likely to be completed within two hours and is highly unlikely to require additional research or information beyond that provided in the offer of proof. However, in one matter, the attorneys were asked to return with additional information for the Tribunal. One attorney seemed affronted by the request and needed the firm instructions of the judge to clarify that the request was within the statute. In my opinion, the judge was much more patient with the attorney than I might have been under similar circumstances.

During the course of the hearing, the Tribunal and families heard stark details from the medical records and in some cases the coroner's report. This

review was particularly difficult for the families. Their outpouring of grief and, in some cases, overt anger was also part of the process.

It is legitimate to question whether using the Tribunal process effectively addresses the malpractice crisis within medicine. Does it make any real difference in the legal experience for the doctor and or health facility, since many cases move on to trial anyway? All medical information heard by the Tribunal on which I served was declared to meet the standard to move forward to trial. Summary judgment for the plaintiff was a possible option for the Tribunal, but was not a result in any of the cases that I heard.

The following composite vignette represents an example of the type of case that I believe could be resolved effectively by the Tribunal. This would enhance the interests of justice and also certainly reduce the financial costs of a protracted lawsuit.

Vignette

Following an order of the court, an individual resident of a state facility was examined by a forensic psychiatrist, whose recommendations were vigorously opposed by the person evaluated. There followed a barrage of threats that culminated in a malpractice lawsuit filed against the examiner. Ultimately, once the matter was before the judge, it was found to be a frivolous action, and summary judgment was ordered for the defendant physician. However, it took four years to move through the courts. Owing to the pending lawsuit, this physician was required to list the details of this suit on applications for medical licensure and for hospital privileges for the four years of the pending lawsuit.

This is the type of frivolous matter in which the Tribunal could be most helpful. First, the plaintiff must have a statement by a professional expert of the facts of the case and must also outline the scope of testimony at trial. In the context of this hypothetical case, there was no requirement to produce a witness statement. The examinee stymied the process of justice for an inordinate amount of time, and the delay had a negative impact on the professional life of the physician.

Summary

As a practicing physician in Massachusetts, I had never considered the role of the Tribunal before serving as a hearing panelist. While any physician who

provides medical care to patients may be subject to a lawsuit, there are factors in the treatment process that represent important elements of the offer of proof against a physician. Poor quality of the patient-doctor relationship and of the doctor's relationship with the family often results in a situation that gives rise to a lawsuit.

The literature has noted the importance of clear and complete documentation in the medical record as an important mechanism of defense in malpractice matters. In one such case forwarded to the Supreme Judicial Appeals Court, the entire record was reviewed by the justices. It was significant to me that the justices took note of and agreed with the medical expert's opinion regarding the poor record keeping and noted that many entries were "illegible."⁸ The clarity and completeness of the medical record, whether written by hand or electronically, are important elements that assist the Tribunal in understanding the plan and course of the medical care offered and in evaluating whether the standard of care was met. It is my impression that physician-defendants, patients, and their families viewed the Tribunal as offering a valuable opportunity to be heard on the merits of the claims.

My service on the Tribunal offered me a view of the medical practice of physician colleagues that is rarely seen outside of hearings before ethics committees and boards of registration of medical licensure. As the other two members of the Tribunal have backgrounds in law, they needed and depended on my

medical expertise to clarify certain aspects of the standard of medical practice. In states in which the Tribunal remains a preliminary step before instituting malpractice litigation, physicians are an important presence.

Still, I am not convinced that this is the best process available today to address the ongoing liability crisis. The experience in Michigan and other states with the "apology system" appears to offer other options that respectfully address the needs of patients and protect physicians. In the interim, the Tribunal remains a mechanism that was a leader in its time in the liability crisis. However, the time has come to consider other innovative options.

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