Washington and Lee Law Review

Volume 34 | Issue 4 Article 8

Fall 9-1-1977

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Alternatives To The Medical Malpractice Phenomenon: Damage Limitations, Malpractice Review Panels And Countersuits, 34 Wash. & Lee L. Rev. 1179 (1977).

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ALTERNATIVES TO THE MEDICAL MALPRACTICE PHENOMENON: DAMAGE LIMITATIONS, MALPRACTICE REVIEW PANELS AND COUNTERSUITS

When a physician offers his professional services, he subjects himself to the possibility of facing a lawsuit for medical malpractice.[1] Since the first reported American medical liability case in 1794,[2] physicians have been held to a standard of care that reflects reasonable skill and learning exercised by other members of the profession following the same school of medical thought and practicing in the same general locality.[3] The number of malpractice actions brought by dissatisfied patients against members of the medical profession has been rapidly increasing.[4] Among the reasons attributed to this in-

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[1] Medical malpractice is defined as the "wreaking of bodily harm by virtue of neglect, abandonment, or the omission or commission of certain actions which fall below the standards of the average medical practitioner." Brooke, *Medical Malpractice: A Socio-Economic Problem from a Doctor's View*, 6 WILLAMETTE L. J. 225, 225 (1970) [hereinafter cited as Brooke]. *See* Brant, *Medical Malpractice Insurance: The Disease and How to Cure it*, 6 VAL. U. L. REV. 152 (1972). The possibility of a doctor being subjected to a medical malpractice suit has increased in recent years. In Virginia, for example, the number of claims per 100 doctors rose from 2.6 in 1969 to 7.2 in 1975. Average jury awards per claim in Virginia increased from $4,182.03 in 1969 to $10,190.66 in 1975. STATE CORPORATION COMMISSION, MEDICAL MALPRACTICE INSURANCE IN VIRGINIA: THE SCOPE AND SEVERITY OF THE PROBLEM AND ALTERNATIVE SOLUTIONS 19 (1975) [hereinafter cited as S.C.C.].

[2] Cross v. Guthrey, 11 Conn. (2 Root) 90 (1794). *See* Stetler, *The History of Reported Medical Professional Liability Cases*, 30 TEMP. L. Q. 366, 367 (1957).

[3] Davis v. Duplantis, 448 F.2d 918, 920 (5th Cir. 1971); Riley v. Layton, 329 F.2d 53, 56 (10th Cir. 1964); Dunham v. Elder, 18 Md. App. 360, 306 A.2d 568, 570 (Ct. Spec. App. 1973); McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 559 (1959). Plaintiffs in malpractice actions are required to prove that the physician's conduct did not conform to the customary practice of the medical profession. 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE, ¶ 8.04 (1973). *See* Note, *The Role of Custom in Medical Malpractice Litigation*, 55 B.U. L. REV. 647 (1975). A plaintiff in a medical malpractice action is relieved of this aspect of his burden of proof when "the results of medical treatment are so patently obvious as to be manifest to lay persons." Collins v. Meeker, 198 Kan. 390, 424 P.2d 488, 493 (1967). *See e.g.*, Wharton v. Warner, 75 Wash. 470, 135 P. 235, 237-38 (1913) (12-inch metal spring lost in patient's uterus).

Recently, courts have strayed from strict compliance with the locality rule. In cases concerning specialists, courts have not only used the locality rule but have also used the "same general neighborhood" rule and the "average specialist" rule. The "same general neighborhood" rule establishes a higher standard than the locality rule by comparing practices within a wider geographical area than the defendant physician's community, thus exposing his standard of care to another community which

crease are the expansion of professional liability insurance, a greater public awareness of medical advances without a corresponding realization of the continued inexactness of medicine, a general increase in all kinds of personal injury claims, and the erosion of the personal physician-patient relationship because of increased medical specialization.[5] In addition, there has been a legislative[6] and judicial[7] liberali-

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may be larger and have better access to advanced medical facilities. *See, e.g.*, Campbell v. Oliva, 424 F.2d 1244 (6th Cir. 1970). The "average specialist" rule imposes an even higher standard of care based on the present level of knowledge within a particular specialized field and is not dependent on any geographical boundaries. *See, e.g.*, Kronke v. Danielson, 108 Ariz. 400, 499 P.2d 156 (1972).

Additional changes concerning a physician's standard of care in regard to the "average specialist" rule are reflected in Helling v. Carey, 83 Wash.2d 514, 519 P.2d 981 (1974). In *Helling*, testimony by medical experts established that the defendant physicians' conduct in treating the plaintiff's eye problems met the standard of care of the average specialist in the same field of medicine. *Id.* at 982. Nevertheless, the court ruled as a matter of law that the defendants were liable for the plaintiff's injuries because it is ultimately the court who must determine the degree of care required. *Id.* at 983. In effect, the *Helling* court created its own standard of care. By abandoning the traditional standards, *Helling* is believed by many commentators to indicate a trend toward strict liability in medical malpractice. *See* Comment, *Medical Malpractice: A Move Toward Strict Liability,* 21 LOY. L. REV. 194, 207-11 (1975); 1975 B.Y. L. REV. 572, 575; Note, *The Role of Custom in Medical Malpractice Litigation,* 55 B.U. L. REV. 647 (1975).

[4] *See* note 1 *supra.* The increase in litigation has led to what has been termed a "medical malpractice crisis" that has manifested itself through increased premium rates and the unavailibility of insurance carriers for health care providers. Jones v. State Board of Medicine, 97 Idaho 859, 555 P.2d 399, 414 (1976). *See* Brown, *Social Resource Allocation Through Medical Malpractice,* 6 WILLAMETTE L. J. 235, 242-47 (1970).

[5] Teahan, *Malpractice—A Review of 174 Claims,* 35 CONN. MED. 81, 82 (1971). For a further discussion of the reasons attributed to the increase in malpractice litigation see Note, *Medical Malpractice Litigation: Some Suggested Improvements and a Possible Alternative,* 18 U. FLA. L. REV. 623 (1966).

[6] One example of legislative liberalization in the area of malpractice litigation is statutorily allowing plaintiffs to present causes of action to the jury without using an expert witness. The plaintiff is allowed to use books and treatises authored by recognized experts. *E.g.*, MASS. GEN. LAWS ANN. ch. 233 § 79 (c) (Supp. 1976). *See* Note, *Overcoming the "Conspiracy of Silence:" Statutory and Common Law Innovations,* 45 MINN. L. REV. 1019 (1961). Although this legislative liberalization has helped malpractice plaintiffs overcome the conspiracy of silence, *see* note 7 *infra,* it has been criticized on the grounds that excerpts from books could be used out of context and a jury would be better able to understand a live witness rather than a book filled with technical terminology. Kroll, *The Etiology, Pulse, and Prognosis of Medical Malpractice,* 8 SUFFOLK U. L. REV. 598, 610 n. 46 (1974). An additional criticism of the use of books is that their authors are not available for cross-examination. 6 J. WIGMORE, EVIDENCE § 1690 at 2 (Chadborn rev. 1976).

[7] Judicial liberalization has resulted from changes in the use of expert testimony.

zation of the laws governing medical malpractice. In response to this problem, physicians on their own have sought to decrease the possibility of facing a malpractice suit. One method increasingly used is the countersuit against the malpractice plaintiff and often his attorney.[8] Further, as a result of encouragement by the medical profession,[9] many states have enacted legislation attempting to eliminate frivolous malpractice actions and limit exorbitant damage awards.[10] Among the alternatives that legislatures have enacted[11] are provisions

Traditionally, the medical profession has been embraced in a "conspiracy of silence," as evidenced by a reluctance of physicians to testify against their fellow practitioners. *See* L'Orange v. Medical Protective Co., 394 F.2d 57 (6th Cir. 1968). As a result, plaintiffs may find it difficult to obtain medical experts willing to testify. To amend the situation, courts have applied the doctrine of res ipsa loquitur in the area of medical malpractice. Siverson v. Weber, 57 Cal.2d 834, 372 P.2d 97, 22 Cal. Rptr. 337 (1962); Mayor v. Dowsett, 240 Or. 196, 400 P.2d 234 (1965). *See* Comment, *Res Ipsa Loquitur in Medical Malpractice Cases in Oregon*, 6 WILLAMETTE L. J. 253 (1970). Under this doctrine, a plaintiff can establish his case without using expert testimony if he shows that an injury doesn't normally occur in the absence of negligence, that the instrument causing the injury was under the defendant's control at all times, and that the plaintiff was not contributorily negligent. W. PROSSER, LAW OF TORTS § 39 at 214 (4th ed. 1971). *See generally* Broder, *Res Ipsa Loquitur in Medical Malpractice Cases*, 18 DE PAUL L. REV. 421 (1969); Knisely, *Modern Medico-Legal Trends*, 25 OHIO ST. L. J. 360, 365 (1964).

[8] Cohn, *The Malpractice Battle*, The Washington Post, Apr. 1, 1977, at C1, col. 1. District of Columbia Medical Society officials have asked Washington doctors to create a $100,000 fund to fight "frivolous and unfounded" malpractice actions. An Independent Legal Resources fund is being proposed to finance suits against lawyers and plaintiffs who file malpractice suits with no basis in fact. *Id. See* text accompanying notes 111-141 *infra*.

[9] The medical profession has taken the attitude that it is socially desirable for physicians to be allowed to work with the knowledge that if they practice within accepted standards they will be free from malpractice exposure. The profession believes that the United States cannot afford a paranoid physician population. Charfoos, *HELLING: The Law of Medical Malpractice Rewritten*, 2 OHIO N. L. REV. 692, 703 (1975).

[10] For a state-by-state analysis of recent legislative activities concerning medical malpractice see HEALTH POLICY CENTER, GEORGETOWN UNIVERSITY, A LEGISLATOR'S GUIDE TO THE MEDICAL MALPRACTICE ISSUE 12 (1976) [hereinafter cited as LEGISLATOR'S GUIDE]; Comment, *An Analysis of State Legislative Responses to the Medical* Malpractice Crisis, 1975 DUKE L. J. 1417.

[11] Various methods that have been considered and enacted by state legislatures to limit the increase in malpractice litigation include a hospital or physician-owned insurance company (Iowa, Maryland, New Jersey, North Dakota); a state-managed insurance fund (eight states including Florida, Michigan, New York and Pennsylvania); a Joint Underwriter's Association in which insurance companies would be compelled to provide regulated coverage with provisions for the sharing of losses or gains (twenty-four states including California, Georgia, Maryland, New York, North Carolina and South Carolina) and provisions whereby a physician and a patient as a

for malpractice review panels which give opinions on the efficacy of claims,[12] and statutes limiting the amount of damages recoverable in a malpractice action.[13]

In *Wright v. Central Du Page Hospital Association,*[14] the Illinois Supreme Court considered the constitutionality of a state statute limiting recovery in a medical malpractice action to $500,000.[15] The plaintiff contended that, by denying recovery for damages in excess of $500,000, the Illinois legislature had "arbitrarily classified, and unreasonably discriminated against" those victims of medical malpractice who are most seriously injured.[16] The defendants argued that such unequal treatment was necessary to contend with the "malpractice crisis."[17] To support their argument, the defendants relied on the Illinois Workmen's Compensation Act as precedent for the constitutional limitation of damages recoverable for personal injuries.[18] The Workmen's Compensation Act provides a *quid pro quo* whereby the employer assumes liability without fault, but is relieved of the burden of large damage judgments. The employee, although limited in the amount he could recover, is awarded compensation without regard to the employer's negligence and is assured a quick,

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condition precedent to treatment would sign an agreement providing for arbitration of any medical malpractice issues that may subsequently arise. LEGISLATOR'S GUIDE, *supra* note 10 at 4-11. *See e.g.*, VA. CODE § 8-503 (Cum. Supp. 1976).

[12] *See* text accompanying notes 46-110 *infra.*

[13] *See* text accompanying notes 14-45 *infra.* Among the states that have enacted statutes limiting damages in medical malpractice actions are Virginia: VA. CODE § 8-654.8 (Cum. Supp. 1976) ($750,000); Illinois: ILL. REV. STAT. ch. 70 § 101 (Supp. 1975) ($500,000); Indiana: IND. CODE ANN. § 16-9.5-2-2 (Burns Cum. Supp. 1976) ($500,000); Idaho: IDAHO CODE § 39-4204 (Supp. 1976) ($150,000 per person, $300,000 per occurence).

[14] 63 Ill.2d 313, 347 N.E.2d 736 (1976).

[15] ILL. REV. STAT. ch. 70 § 101 (Supp. 1975). In *Wright,* the plaintiff brought an action to recover damages from the hospital association and her treating physician for personal injuries suffered while the plaintiff was at the hospital under her physician's care. The plaintiff sought declaratory relief concerning the constitutionality of various sections of the Illinois medical malpractice statutes. 347 N.E.2d at 737. The court not only overturned the statute limiting damages, but also found unconstitutional a statutory provision regulating the rates of medical malpractice insurance policies and other statutory provisions relating to the establishment of medical malpractice review panels. *Id.* at 734. *See* text accompanying notes 75-85 *infra.*

[16] 347 N.E.2d at 741. The plaintiff claimed that the legislature's effort to reduce or maintain malpractice insurance premiums by limiting damages placed the burden of those limitations solely on those unfortunate victims of serious malpractice who need the most financial protection. *Id.*

[17] *Id.* at 741, *citing* Cunningham v. Brown, 22 Ill.2d 23, 174 N.E.2d 153 (1961); Hall v. Gillins, 13 Ill.2d 26, 147 N.E.2d 352 (1958).

[18] ILL. REV. STAT. ch. 48, §§ 138.1 *et. seq.* (Supp. 1975).

effortless recovery.[19] Similarly, the defendants contended, there exists a societal *quid pro quo* whereby the loss of potential recovery to a few medical malpractice victims is compensated for by lower insurance premiums and lower medical care costs for the public.[20] The Illinois court rejected the defendants' *quid pro quo* argument and held that the rationale did not extend to the seriously injured medical patient.[21] The court further ruled that, to the extent "recovery is permitted or denied on an arbitrary basis," there had been a special privilege granted in violation of the Illinois Constitution.[22] On the basis of the court's finding of arbitrariness, the statute limiting damages to $500,000 was held to be violative of the Illinois Constitution.[23]

The Illinois court's finding that the state legislature could not constitutionally limit the amount of damages because such legislation would constitute a special law[24] is a proper adjudication of the damage limitation issue.[25] By effectively precluding those patients who have suffered serious injury from recovering amounts in excess of $500,000, the Illinois statute wrongfully altered a common law right of recovery without a concomitant *quid pro quo.*[26]

The constitutionality of a damage-limiting statute was also considered by the Idaho Supreme Court in *Jones v. State Board of*

[19] *See* Moushon v. National Garages, Inc., 9 Ill.2d 407, 412, 137 N.E.2d 842,845 (1956).

[20] 347 N.E.2d at 742.

[21] *Id.* The court reasoned that although the Workmen's Compensation Act requires the employee to give up certain recoverable damages, it does provide for the payment of medical expenses and compensation for the duration of the employee's incapacity. Conversely, the statute limiting damages in a medical malpractice action abolished no common law defenses and did not alter the essential elements for a cause of action for medical malpractice. In addition, a seriously injured malpractice victim might not be able to recover even all the medical expenses he may have incurred. *Id.*

[22] *Id.* at 743. ILL. CONST. art. 4, § 13, entitled "Special Legislation," states that "[t]he General Assembly shall pass no special or local law when a general law is or can be made applicable. Whether a general law is or can be made applicable shall be a matter for judicial determination." *See* Grace v. Howlett, 51 Ill.2d 478, 283 N.E.2d 474, 478 (1972); Bridgewater v. Hotz, 51 Ill.2d 103, 281 N.E.2d 317, 321 (1972).

[23] 347 N.E.2d at 743.

[24] *See* note 22 *supra.*

[25] Statutes limiting damages may constitute reform that may be instituted "one step at a time" and therefore, do not fall within the classification of unreasonableness and arbitrariness. 347 N.E.2d at 743. *See* Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 489 (1955). Nevertheless, Illinois courts have consistently held that when recovery is denied on an arbitrary basis, a special privilege has been granted in violation of the Illinois Constitution. Grace v. Howlett, 51 Ill.2d 478, 283 N.E.2d 474, 479 (1972); Harvey v. Clyde Park Dist., 32 Ill.2d 60, 203 N.E.2d 573, 576 (1964).

[26] The right to recover damages for injuries suffered from medical malpractice existed at common law. *E.g.,* Ritchey v. West, 23 Ill. 329 (1860). *See* notes 1 & 21 *supra.*

Medicine.[27] In *Jones,* the appellant State Board of Medicine challenged a lower court ruling that an Idaho statute limiting damages in a medical malpractice action was unconstitutional.[28] Respondents argued that by limiting recovery in malpractice actions, the Idaho statute created a classification which is discriminatory and violative of the equal protection clauses of both the Federal[29] and the Idaho Constitutions.[30] This argument was based on the statute's differentiation between those who are injured in amounts exceeding the statutory limit and those damaged in amounts less than the statutory limit. Respondents also urged that in view of the Illinois court's holding in *Wright,*[31] the Idaho statute should be found to be violative of the prohibition against special legislation in the Idaho Constitution.[32] Examining the purpose of the damage-limiting statute, the court concluded that if the statute was enacted in response to the growing malpractice problem, and if it served the health and welfare of the people of Idaho, then it would survive the equal protection and special legislation challenges.[33] The court found that the appellants had not introduced enough evidence to support a finding on the purpose of the statute. Consequently, the case was remanded to the trial court for additional evidence.[34]

The *Jones* court failed to recognize that the real victims of the medical malpractice crisis are those patients who are seriously injured through a physician's negligence and who are precluded from recovering more than $150,000 in damages. The Idaho court appeared

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[27] 97 Idaho 859, 555 P.2d 399 (1976).

[28] 1975 Hospital-Medical Liability Act, codified at IDAHO CODE § 39-4204 (Supp. 1976). The Act was enacted in response to the "alleged 'medical malpractice insurance crisis'." 555 P.2d at 402. Included within the Act are provisions that limit the recoverable damages for actions against physicians at $150,000 per claim and $300,000 per occurrence. *Id.*

[29] U.S. CONST. amend. XIV provides that "[n]o State shall . . . deny to any person within its jurisdiction the equal protection of the laws."

[30] IDAHO CONST. art. I, § 2 provides that "[a]ll political power is inherent in the people. Government is instituted for their equal protection and benefit. . . ."

[31] *See* text accompanying notes 14-26 *supra.*

[32] IDAHO CONST. art. III, § 19 provides in part:

> The legislature shall not pass local or special laws in any of the following enumerated cases, that is to say: . . . Releasing or extinguishing, in whole or in part, the indebtedness, liability or obligation of any person or corporation in this state, or any other municipal corporation therein. . . .

[33] 555 P.2d at 411,417.

[34] Although the Idaho court did not specifically state who was to gather the additional evidence, apparently this burden would be on the appellants. *See id.* at 417.

to refute its own conclusions by noting that, nationally, fewer than one percent of all malpractice recoveries in 1970 were in excess of $100,000, and that in 1974 the average settlement for a claim was $12,535.[35] The *Jones* court added that in 1970, medical malpractice insurance losses in Idaho constituted less than one-tenth of one percent of the national total.[36] Statistically, the Idaho malpractice claim in excess of $100,000 is a rarity, and yet the *Jones* court believed that by limiting damages to $150,000 the medical malpractice problem could be alleviated.[37]

Virginia's damage-limiting statute for medical malpractice cases has yet to be judicially examined. By allowing damage recoveries up to $750,000,[38] the Virginia statute appears to be more quantitatively reasonable than the Idaho statute.[39] Nevertheless, the Virginia enactment faces the same constitutional challenge of "special privilege" that invalidated the Illinois statute in *Wright*.[40] The Virginia Constitution prohibits the enactment of special legislation that changes the methods of enforcing judgments.[41] Therefore, the Virginia statute may constitute special legislation by limiting the common law right of recovery for medical malpractice to $750,000. As in Idaho,[42] claims in Virginia above the statutory limit have been extremely rare.[43] This

[35] *Id.* at 414-15.

[36] *Id.* at 415.

[37] *Id.* at 417.

[38] VA. CODE § 8-654.8 (Cum. Supp. 1976) states:

> In any verdict returned against a health care provider in an action for malpractice where the act or acts of malpractice occurred on or after [April 1, 1977] which is tried by a jury or in any judgment entered against a health care provider in such an action which is tried without a jury, the total amount recoverable for any injury to, or death of, a patient shall not exceed [$750,000].

[39] *See* note 28 *supra*.

[40] *See* text accompanying notes 14-26 *supra*.

[41] Although the Virginia Constitution is not identical to the Illinois Constitution regarding the prohibition of special legislation, *see* note 22 *supra*, the Virginia Constitution does state that "[t]he General Assembly shall not enact any local, special, or private law in the following cases: . . . 3) Regulating the practice in . . . or providing or changing the methods of . . . enforcing judgments . . . ." VA. CONST. art. 4, § 14. *See* Harlan, *Virginia's New Medical Malpractice Review Panel and Some Questions it Raises*, 11 U. RICH. L. REV. 51, 67 (1976) [hereinafter cited as Harlan].

[42] *See* text accompanying note 37 *supra*.

[43] From 1970 to 1975 no claim for medical malpractice in Virginia was reported in excess of $500,000, and only one claim was settled for $250,000. S.C.C., *supra* note 1, at 28. The average malpractice verdict against Virginia physicians in 1975 was $10,000. *Id.* at 19. In 1976, however, a verdict of $725,000 was returned against a number of health care providers jointly. Baley v. Luthey, Civ. No. 12229 (Hampton, Va. Cir. Ct., May 24, 1976).

fact would seem to preclude the necessity of a statute limiting damages since malpractice suits in excess of $750,000 pose no real threat in Virginia. Nevertheless, placing limitations on damages prevents those few people whose injuries represent more than $750,000 from fully recovering.

Allowing victims of medical malpractice to recover damages for their injuries is one way that society can ease their pain and suffering.[44] To restrict these victims to an arbitrary sum is to compound the damage done by a negligent physician.[45] By limiting such damages through the enactment of statutes, state legislatures have failed in this attempt to alleviate a "malpractice crisis."

In addition to statutes limiting damages in a medical malpractice action, state legislatures have also instituted provisions for medical malpractice review panels.[46] While damage-limiting statutes evidence an attempt by state legislatures to deal with the medical malpractice problem at the end of the litigation continuum, medical malpractice review panels attempt to confront the problem at the start of the litigation process. Malpractice review panels have had their genesis in a general dissatisfaction with the traditional procedure of medical malpractice cases.[47] Among the major difficulties with the traditional procedure of medical malpractice cases for plaintiffs are long delays between the filing of the suit and final disposition, resulting in unreasonable delays for compensation of valid claims; problems in obtaining medical experts to assist in case preparation and testifying; and high costs for case preparation, including experts' fees.[48] From the defendant physician's viewpoint, traditional litigation procedures present opportunities for patients to file unjustified or nuisance suits which can damage a physician's reputation and practice.[49] In addition, the complex nature of many malpractice cases

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[44] Fuchsberg, *Myths of Medical Malpractice*, 11 TRIAL LAW Q. 49, 55 (Spring/Summer 1976) [hereinafter cited as Fuchsberg].

[45] *Id.* One example of the inadequacy of damage-limiting statutes is the hypothetical situation of a young, talented doctor or lawyer who is permanently injured through the negligence of a physician. A statute like Idaho's limiting damages against the negligent physician to $150,000 would obviously not begin to cover the loss of future earnings for a young professional.

[46] *See* note 51 *infra*.

[47] *See* text accompanying notes 51-54 *infra*.

[48] Note, *Medical-Legal Screening Panels as an Alternative Approach to Medical Malpractice Claims*, 13 WM. & MARY L. REV. 695, 709-10 (1972) [hereinafter cited as *Screening Panels*].

[49] *Screening Panels*, *supra* note 48, at 709. One result of using traditional litigation procedures is the practice of "defensive medicine" by physicians to lessen the chances for a malpractice suit. Such "defensive medicine," consisting of copious diagnostic

has created problems for the trier of fact in making competant determinations of whether a physician is liable for professional negligence.[50] Attempting to alleviate some of the difficulties with the traditional procedure of malpractice cases, many states have established medical malpractice review panels to prevent unjustified or nuisance suits and to help dispose of claims that appear valid.[51] The medical profession fears malpractice suits, even if ill-founded, because of their possible adverse effects upon an individual's reputation.[52] Aware of this fear, legislatures have instituted review panels for the purpose of curtailing frivolous actions.[53] The panels also recognize the difficulty plaintiffs have in obtaining expert witnesses to testify in legitimate suits, and therefore arrange for expert witnesses to testify on behalf of the plaintiff.[54]

Virginia's provisions for medical malpractice review panels exemplify how state legislatures have attempted to solve some of the prob-

tests and a reluctance to try innovative procedures, represents a major part of the crisis over the cost of health care. *Id.* at 709-10. Although the most immediate cost affects the patient in the form of higher medical bills, of more consequence is the "opportunity cost" or "alternate use cost" resulting from a misallocation of medical resources. The overall effect is a reduction in the quantity of care available for legitimate health needs at a time when the demand and need for medical care exceeds the supply. Project, *The Medical Malpractice Threat: A Study of Defensive Medicine,* 1971 DUKE L. J. 939, 943.

[50] *Screening Panels, supra* note 48, at 710. *See* e.g., Anderson v. Florence, 288 Minn. 351, 181 N.W.2d 873 (1970); Hoffman v. Naslund, 274 Minn. 521, 144 N.W.2d 580 (1966).

[51] Among the more than thirteen states that have established malpractice review panels are: Arizona, Colorado, Nevada, New Jersey, New Mexico, New York and Virginia. In 1962, through the joint efforts of the Virginia State Bar and Medical Society of Virginia, a "Joint Screening Panel" was established for the discretionary use of malpractice claimants. The purpose of the Joint Screening Panel was to prevent frivolous claims from being filed against physicians, and to assist in the preparation of reasonable claims through the use of medical experts. Harlan, *supra* note 41, at 51. Because it required the plaintiff's attorney to withdraw from the case in the face of an adverse ruling, the "Joint Screening Panel" was rarely used. *Id.* After considering a number of alternatives to dealing with the growing malpractice problem, *see* note 11 *supra,* the Virginia General Assembly in 1976 created provisions for medical malpractice review panels. VA. CODE §§ 8-911 to 922 (Cum. Supp. 1976). Unlike the previous provisions for a Joint Screening Panel, the 1976 statute does not require the withdrawal from the case of the plaintiff's attorney in the face of an adverse ruling.

[52] *Screening Panels, supra* note 48, at 702. *See* Adler, *Malicious Prosecution Suits as Counterbalance to Medical Malpractice Suits,* 21 CLEV. ST. L. REV. 51,53 (1972) [hereinafter cited as Adler].

[53] *Screening Panels, supra* note 48, at 705. Typically the panel considers whether there is substantial evidence of malpractice and whether there is a reasonable medical probability that the claimant was injured by the negligent act. *Id.* at 706.

[54] *Id.* at 705.

lems of medical malpractice litigation.[55] The Virginia statute requires the panel to include three impartial attorneys and three impartial health care providers,[56] all of whom are licensed and actively practicing their professions in the congressional district where suit would be brought.[57] A Virginia circuit court judge serves as chairman of the panel, and he can vote only in case of a tie.[58] An obvious deficiency in the panel structure is the requirement that the panel members be from the same congressional district as the defendant doctor. Although this requirement apparently relates to the "community standard of care" doctrine,[59] the practical effect of this requirement would be to hamper the panel's impartiality by limiting members to professionals in close geographical proximity to the defendant.[60]

Before an action is commenced under the Virginia system, the patient must give the health care provider written notification of the acts of alleged malpractice and the date on which the alleged events occurred.[61] From the time of this notice, either the potential plaintiff or the health care provider may file a request within 60 days with the Chief Justice of the Supreme Court of Virginia for the case to be reviewed by a Medical Malpractice Review Panel.[62] The statute further provides that a malpractice action cannot be brought within 90 days of the claimant's notification to the health care provider, and if a review panel is requested, within its period of review.[63] After notice of a claim has been given to the health care provider, the statute of limitations is tolled[64] for 120 days or 60 days after the issuance of the

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[55] VA. CODE §§ 8-911 to 922 (Cum. Supp. 1976).

[56] The term "health care provider" includes doctors, dentists, nurses, hospitals, nursing homes and other licensed individuals, facilities or institutions. VA. CODE § 8-911(i) (Cum. Supp. 1976).

[57] VA. CODE § 8-913 (Cum. Supp. 1976).

[58] *Id.*

[59] Part of a plaintiff's burden of proof in a medical malpractice action is the showing of a violation of the physician's "community standard of care". *See* text accompanying note 3 *supra*. The community standard of care is utilized in malpractice actions in Virginia. *E.g.* Little v. Cross, 217 Va. 71, 225, S.E.2d 387 (1976).

[60] Harlan, *supra* note 41, at 54.

[61] VA. CODE § 8-912 (Cum. Supp. 1976).

[62] *Id.*

[63] *Id.*

[64] VA. CODE § 8-24 (Cum. Supp. 1976) provides that every action for personal injury must be brought within two years after the accrual of the right to bring the action. The statute of limitations begins to run from the moment the cause of action accrues and not when it is subsequently discovered by the injured patient. Hawks v. DeHart, 206 Va. 810, 146 S.E.2d 187 (1966) (cause of action began when pin left in plaintiff's neck, not 17 years later when discovered). *See* Morgan v. Schlanger, 374 F.2d 235, 239 (4th Cir. 1967); *Cf.* Burton v. Terrell, 368 F. Supp. 553, 557 (W.D. Va. 1973)

review panel's opinion, whichever is later.[65]

Once the medical review panel has received all evidence pertinent to the action, it is required to render one or more of the following opinions: that the plaintiff's claim has no merit; that the health care provider failed in meeting his standard of care, which was the proximate cause of the alleged injury; that although the health care provider failed in meeting his standard of care, the failure was not the proximate cause of the alleged injury; or that there is an outstanding issue of fact concerning liability which is the proper subject for a court's or jury's consideration in a trial.[66]

The opinion of the medical malpractice review panel is significant in that it may be admitted into evidence in any malpractice action subsequently brought by the claimant.[67] Although the opinion is not conclusive and either party has the right to call any member of the panel as a witness, the use of this extra-judicial board's opinion will certainly affect the character of a malpractice action through its influence over the jury and alterations of the rules of evidence.[68] The Virginia Constitution places great importance upon the right to a civil trial by jury.[69] By allowing the panel's opinion to be admitted

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(fraudulant sale of land). *But see* Comment, *Discovery Rule: Accrual of Cause of Action for Medical Malpractice*, 25 WASH. & LEE L. REV. 78 (1968). Contrarily, the "discovery" rule provides for the accrual of a cause of action for medical malpractice when the patient learns, or should have learned, of the presence of a foreign object in his body. *E.g.* Gaddis v. Smith, 417 S.W.2d 577 (Tex. 1967).

[65] VA. CODE § 8-919 (Cum. Supp. 1976).

[66] *Id.* at § 8-917 (A). The statute also provides that the review panel's findings may include a determination of whether the claimant suffered any disability or impairment and the extent of those injuries. *Id.* at § 8-917(B).

[67] *Id.* at § 8-918.

[68] Harlan, *supra* note 41, at 61-63. Alterations in the rules of evidence through the use of malpractice review panels may occur in at least two ways. First, evidence to be submitted to the panel is required to be in written form only. Upon this evidence the panel can make its decision without a hearing or without allowing adverse parties the opportunity to cross-examine witnesses. VA. CODE § 8-914 (Cum. Supp. 1976). This decision could then be introduced at the subsequent trial, void of evidential safeguards that may have changed its substance. Second, the panel may choose to hold a hearing in which the rules of evidence would not be applicable. *Id.* at § 8-916(ii). If the panel's opinion were based on evidence that would be otherwise inadmissible at trial, the issue arises whether this would preclude the use of the panel's opinion in the subsequent trial. Harlan, *supra* note 41, at 63. The statute does not address this issue and apparently the opinion of the panel could be used at trial anyway. *Id.* The problem with allowing the panel to consider evidence that would be inadmissible at trial is that a party adverse to the panel's opinion could argue that the opinion itself is inadmissible evidence. *Id.*

[69] VA. CONST. art. I, § 11 provides in part "[t]hat in controversies respecting property, and in suits between man and man, trial by jury is preferable to any other,

into evidence, the legislature has allowed the jury to be subject to undue influence,[70] resulting from the esteem the expert members of the panel would command from the jurors.[71]

Disregarding the degree of undue influence as violative of the Virginia Constitution, the statute may additionally be subject to a constitutional attack upon the powers of the panel. The Constitution of Virginia provides that the judicial power shall be vested in the Supreme Court and any other subordinate courts that the legislature may establish.[72] The Virginia Constitution also places limitations upon the legislature with regard to judicial functions by prohibiting the enactment of any law that regulates judicial proceedings.[73] By giving to members of the panel judicial powers of hearing evidence and deciding questions of law and fact, the Virginia legislature may have violated the state constitution by assigning a judicial function to a non-judicial panel.[74]

The Illinois Supreme Court in *Wright v. Central Du Page Hospital Association*[75] declared a statute providing for medical malpractice review panels[76] unconstitutional.[77] The court held that nonjudicial members of the panel, by being allowed to make conclusions of law and fact, were improperly empowered with judicial functions[78] in violation of the Illinois Constitution.[79] Further, the court determined

and ought to be held sacred."

[70] The possibility of undue influence in a medical malpractice action is great. The complexity of the subject matter combined with the expertise and official nature of the members of the panel could very likely lead a jury to place too much emphasis on the panel's opinion. *See* Harlan, *supra* note 41, at 62.

[71] *Id.*

[72] VA. CONST. art. VI, § 1.

[73] VA. CONST. art. IV, § 14 provides that "[t]he General Assembly shall not enact any local, special, or private law in the following cases: . . . 3) Regulating the practice in, or the jurisdiction of, or changing the rules of evidence in any judicial proceedings or inquiry before the courts or other tribunals. . . ."

[74] *See* note 68 *supra*. Review panels differ from other non-judicial bodies such as the State Corporation Commission, which received its judicial power through the state constitution, VA. CONST. art. IX, §§ 1 & 2, and which is required to observe the common law and statutory rules of evidence when it is called upon to render judgments. VA. CODE § 12.1-30 (1973).

[75] 63 Ill.2d 313, 347 N.E.2d 736 (1976). *See* text accompanying notes 14-25 *supra*.

[76] ILL. REV. STAT. ch. 11, §§ 58.2 to 58.10 (Cum. Supp. 1975).

[77] 347 N.E.2d at 741.

[78] 347 N.E.2d at 739-40.

[79] ILL. CONST. art. VI, § 1 states that "[t]he judicial power is vested in a Supreme Court, an Appellate Court and Circuit Courts." ILL. CONST. art. VI, § 9 provides in part that "Circuit Courts shall have original jurisdiction of all justiciable matters except when the Supreme Court has original and exclusive jurisdiction. . . ."

that the right to a jury trial in a civil case was impermissibly restricted by the procedure prescribed for medical review panels.[80]

Differences exist between the Illinois and Virginia review panel statutes which might save the Virginia statute from the constitutional attack that invalidated the Illinois statute. The Illinois statute required all medical malpractice cases to be heard by a review panel,[81] while the Virginia statute provides for the convening of a review panel at the discretion of either party.[82] The coercive nature of the Illinois statute was one of the factors that led to a finding of its unconstitutionality,[83] but this would not be a factor in a consideration of the Virginia statute. In addition, the Illinois statute allowed parties to agree to be bound by the determination of the panel and judgment could be rendered thereon.[84] The Virginia statute, on the other hand, allows only for the admissibility of the panel's opinion at the subsequent trial and does not provide for parties to be bound by the panel's opinion.[85]

A lower New York state court recently upheld the constitutionality of a review panel statute similar to Virginia's in *Comiskey v. Arlen.*[86] The challenged New York statute provides for the admissibility at trial of the unanimous recommendation of the panel concerning liability.[87] The statute provides, however, that the panel's recommendations are not binding on the trier of fact, but shall be given such weight as the jury or trial court decides to ascribe to it.[88] If the panel's recommendations are read to the jury or by the trial court, certain members of the panel may be called as witnesses by either party, but only in reference to the panel's recommendation.[89]

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[80] 347 N.E.2d at 741. ILL. CONST. art I, § 13 states that "[t]he right of trial by jury as heretofore enjoyed shall remain inviolate." This constitutional provision is similar to the jury trial provisions of the Virginia Constitution. *See* note 69 *supra*.

[81] ILL. REV. STAT. ch. 110 § 58.3 (1975) required the circuit court to order the convening of "a medical review panel to which the case shall be assigned for hearing and determination." This panel will convene "[n]o sooner than 120 days nor later than one year after the parties are at issue on the pleadings."

[82] VA. CODE § 8-912 (Cum. Supp. 1976).

[83] The *Wright* court found that review panels were an impermissible restriction on the right to a trial by jury. 347 N.E.2d at 741.

[84] ILL. REV. STAT. ch. 110 § 58.8 (1975).

[85] VA. CODE § 8-918 (Cum. Supp. 1976).

[86] 55 App. Div. 2d 304, 390 N.Y.S.2d 122 (1976).

[87] N.Y. JUD. LAW § 148-a (McKinney Cum. Supp. 1975).

[88] *Id.*

[89] *Id.* Some procedural questions concerning the interpretation of the statute arise, such as whether the party adversely affected by the panel's recommendations has the right to call panel members as witnesses; *see* Harlan, *supra* note 41 at 63, or whether

In *Comiskey,* the review panel had considered all the submitted evidence and concluded unanimously that no malpractice had occurred.[90] The plaintiff moved to suppress the panel's recommendation and requested a special trial on this issue. The trial court held that the statute allowing the admissibility of the panel's conclusions as evidence[91] was unconstitutional. Reversing the trial court, the Appellate Division held that the lower court had prematurely considered the constitutionality of the statute.[92] Stating that constitutional questions should not be considered until their disposition became necessary,[93] the Appellate Division found that constitutional objections would be better handled during the malpractice trial at a time when the panel's recommendation would be offered as evidence.[94] The trial court in *Comiskey* had also concluded that a jury would not be able to weigh objectively the merits of the panel's recommendation, thus depriving the plaintiff of the right to a fair trial.[95] Conversely, the Appellate Division noted that, historically, jurors have proven their independence from matters of undue influence.[96] The panel's recommendation was compared to the testimony of an expert witness, which may be evaluated by the jury in accordance with the judge's instructions.[97] The Appellate Division distinguished its findings from those of the court in *Wright v. Central Du Page Hospital Association*[98]

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these witnesses then will be considered hostile witnesses and therefore be subject to full cross-examination. *See* C. McCormick, Evidence § 19 at 43 (2d ed. E. Cleary 1972).

[90] 55 App. Div. 2d at 306, 390 N.Y.S.2d at 124.

[91] N.Y. Jud. Law § 148-a (McKinney Cum. Supp. 1976).

[92] 55 App. Div. 2d at 306, 390 N.Y.S.2d at 124.

[93] *Id.*

[94] In Halpern v. Gozan, 85 Misc. 2d 753, 381 N.Y.S.2d 744 (Sup. Ct. 1976), the constitutionality of the review panel statute, N.Y. Jud. Law § 148-a (McKinney Cum. Supp. 1976), was determined by the trial court after the panel's recommendations were offered as evidence at the trial.

[95] Comiskey v. Arlen, 45 U.S.L.W. 2019, 2020 (N.Y. Sup. Ct. July 2, 1976).

[96] 55 App. Div. 2d at 307, 390 N.Y.S.2d at 125, *citing* Halpern v. Gozan, 85 Misc. 2d 753, 381 N.Y.S.2d 744 (Sup. Ct. 1976). *But see* text accompanying notes 70 & 71 *supra.*

[97] To justify its comparison of the panel's findings to an expert opinion the *Comiskey* court cited *Ex parte* Peterson, 253 U.S. 300 (1920), in which the Supreme Court held that a federal district court could refer questions of fact to a court appointed non-judicial officer, whose report could be introduced at trail as prima facie evidence of the facts found and the conclusions reached. The Court rationalized its holding by stating that "[t]he command of the Seventh Amendment that 'the right of trial by jury shall be preserved' does not require that old forms of practice and procedure be retained." *Id.* at 309.

[98] 63 Ill.2d 313, 347 N.E.2d 736. *See* text accompanying notes 74-80 *supra.*

because of differences between the New York[99] and Illinois[100] statutes. The *Comiskey* court observed that under the Illinois statute, the panel's recommendation could not be subjected to the jury's scrutiny,[101] while under the New York statute, the jury is free to determine the weight it will give the panel's recommendations. The *Comiskey* court's analysis seems to ignore the possibility that the panel's recommendation might unduly influence the jury.[102]

Since the Virginia review panel statute more closely resembles the New York statute than the Illinois statute,[103] the Virginia statute will probably be subject to judicial scrutiny similar to that made by the *Comiskey* court. The crucial issue that the Supreme Court of Virginia must decide in examining the constitutionality of review panels is whether admission of the panel's recommendation into evidence is an infringement of the qualified right to a jury trial in a civil case.[104] If the Virginia court follows the rationale of the *Comiskey* court, Virginia's review panel statute will probably be upheld.

Although malpractice review panels may be adjudged constitutional, they are beset with many practical problems that restrict their effectiveness. Malpractice review panels depend upon two variables for successful operation. First, there must be cooperation between the medical and bar associations.[105] Second, insurance carriers are needed to support the use of review panels by cooperating with the submission of cases to the panels.[106] This cooperation has often been lacking

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[99] *See* note 87 and text accompanying notes 86-89 *supra*.

[100] *See* note 75 and text accompanying notes 75-85 *supra*.

[101] ILL. REV. STAT. ch. 110, § 58.8 (1975). The opinion of the review panel could not be subject to the jury's scrutiny because both parties could agree to be bound by the opinion and judgment would be entered thereon. If both parties did not agree to be bound, the panel's opinion could not have been admitted into evidence at trial. *Id.*

[102] *See* text accompanying notes 69-71 *supra*.

[103] As in the New York law, the Virginia statute allows for the admission of the panel's recommendation into evidence. Both statutes also provide that the recommendations shall not be binding on the jury. *Compare* N.Y. JUD. LAW § 1480 (McKinney Cum. Supp. 1976) *with* VA. CODE § 8-918 (Cum. Supp. 1976).

[104] *See* text accompanying notes 67-71 *supra*.

[105] *Screening Panels, supra* note 48, at 721. Review panels that have successfully reduced the number of malpractice suits brought before courts have attributed their success to close cooperation between members of the bar and the medical profession. *See id.* at 713-17. This has resulted in noticeable attempts by members of both professions to encourage claimants to submit their actions to the panels. Unfortunately, this inter-professional cooperation has not taken place in urban areas as frequently as in rural areas. Probably the major factor that can be attributed to this lack of cooperation in urban areas is the sheer size and impersonal nature of a highly populated area. *Id.* at 715.

[106] Many insurance companies disfavor review panels. They feel that the proce-

because the use of review panels is voluntary and the decisions made are not binding.[107] Without the support of their insurance carriers, physicians have little incentive to sustain the system of review panels.[108] Additionally, the review panels meet only for brief periods of time, and thus may be unable to review all relevant evidence.[109] Further, they do not hear the testimony of a variety of witnesses and so cannot resolve issues of credibility.[110] Because of the various constitutional and practical problems associated with medical malpractice review panels, they presently are not a reasonably workable solution to the medical malpractice crisis. Until the problems with review panels are resolved through a closer cooperation and understanding between the legal and medical professions, the best arbiter of malpractice claims remains the jury.

Many members of the medical profession believe that legislation has not adequately curtailed the increase of malpractice actions and have therefore begun to utilize the countersuit as a solution to the malpractice crisis. Numerous malpractice actions are brought against physicians without justifiable cause.[111] As a result, many doctors feel that they are entitled to some kind of protection from the harassment of invalid suits.[112] The weapon which some doctors believe may prove most effective is the countersuit based on the theory of malicious prosecution.[113] Malicious prosecution represents an im-

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dure is weighted in favor of the malpractice claimant and that there is pressure to settle because the claimant is guaranteed expert testimony. Insurance carriers also argue that if the claimant fails before the panel, the knowledge he has gained through the panel's hearing may negate the adverse effect of an unfavorable panel vote. *Id.* at 716, *citing* THE MEDICAL PROTECTIVE CO., PRE-TRIAL MALPRACTICE SCREENING PANELS: A COMMENTARY (1970). *See, e.g.,* VA. CODE § 8-918 (Cum. Supp. 1976); N.Y. JUD. LAW § 148-a (8) (McKinney Cum. Supp. 1976).

[107] *See* note 106 *supra.*

[108] *Screening Panels, supra* note 48, at 715.

[109] Fuchsberg, *supra* note 45, at 57.

[110] *Id.*

[111] Compulsory arbitration in Pima County, Arizona, has revealed that 57 of 65 cases arbitrated over a 12-year period were found to be meritless. Brooke, *supra* note 1, at 229. Lawyers reportedly reject nine out of ten prospective malpractice cases, and 30% of the cases brought to court have no merit. *Time,* Nov. 2, 1970 at 36.

[112] Brooke, *supra* note 1, at 226.

[113] *See* Note, MALICIOUS PROSECUTION-ESSENTIAL ELEMENTS, 26 TENN. L. REV. 437 (1959) [hereinafter cited as *Essential Elements].* Historically, malicious prosecution actions have been disfavored as countersuits to civil proceedings. Fearful that threats of counterclaims for malicious prosecution would adversely affect a person's right to bring a cause of action, courts have been reluctant to expand the availability of the remedy. In Melvin v. Pence, 130 F.2d 423, 426 (D.C. Cir. 1942), the court argued against malicious prosecution actions by stating that, a margin of safety in asserting

balance between the conflicting interests of parties to the original civil suit. Plaintiffs are immune from causes of action arising out of their good faith efforts to secure legal or equitable adjudication of their rights.[114] Correspondingly, defendants have the right to be free from unreasonable litigation.[115] The physician's burden of proof in an action for malicious prosecution requires his proving that a malpractice suit was brought against him without probable cause, that there was a malicious motive in bringing the original suit, that the malpractice suit was terminated in his favor, and finally, that the suit resulted in damage.[116]

For a physician to establish that the plaintiff brought a malpractice action without probable cause, he must prove that the plaintiff lacked an honest and reasonable belief that a tenable claim existed.[117] To determine the existence of probable cause, the jury must examine the facts and circumstances surrounding the initial malpractice action. The question is not whether the defendant physician in the initial action was actually liable, but whether there were reasonable grounds for the plaintiff to believe him liable.[118]

Requiring a malicious prosecution action to await termination of the initial suit in favor of the defendant effectively forecloses initiation of countersuits during the pendency of the initial action.[119] The

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rights, though they may be groundless and their assertion accompanied by some degree of ill-will, must be maintained. Otherwise litigation would lead not to an end of disputes, but to a beginning, and rights violated would go unredressed from fear of the danger of asserting them.

[114] Adler, *supra* note 52, at 54.

[115] *Id. See* Note, *Malicious Prosecution: An Effective Attack on Spurious Medical Malpractice Claims?* 26 CASE W. RES. L. REV. 653, 656 (1976) [hereinafter cited as *Malicious Prosecution*]. An individual's right to bring a cause of action must be protected in view of the interest of the citizen to be free from vexatious actions, damage and possible ruin, and the interests of the courts in promoting the honest use of the judicial process. *Id.* at 661.

[116] *Id.* at 657. *See generally* Kauffman v. A.H. Robins Co., 223 Tenn. 515, 448 S.W.2d 400 (1969); Community Natl. Bank v. Burt, 183 So.2d 731 (Fla. App. 1966).

[117] A plaintiff has probable cause to bring an action when he reasonably believes in the existence of facts under which his claim may be valid. *E.g.*, Title Guar. Co. v. Harmer, 482 P.2d 430, 432 (Colo. Ct. App. 1971); Kunz v. Johnson, 74 S.D. 577, 57 N.W.2d 116, 119 (1953).

[118] *Essential Elements, supra* note 114, at 439. *See* Ray v. City Bank & Trust Co., 358 F. Supp. 630 (S.D. Ohio 1973); Kassan v. Bledsoe, 252 Cal. App.2d 810, 60 Cal. Rptr. 799 (1967).

[119] An action for malicious prosecution cannot be asserted through a cross-complaint or counterclaim in the original proceeding, prior to its termination, since the original proceeding must have been previously terminated in favor of the party bringing the malicious prosecution action. Bollinger v. Jarret, 146 Mont. 355, 406 P.2d

termination rule prevents inconsistent judgments where a plaintiff might prevail in his original action, yet fail on the countersuit for malicious prosecution.[120] The rule also prevents prejudice to the original action when evidence is introduced in the countersuit concerning malice and lack of probable cause.[121]

In addition to the requirement of a favorable termination, a showing of malice is essential to a malicious prosecution countersuit.[122] Malice can include evidence of ill will, anger, or absence of a bona fide belief of fault.[123] Actual proof of malice may be inferred from the circumstances indicating a lack of probable cause.[124] It is difficult for a physician to prove malice because he is required to show that the plaintiff knew he had no case when he brought the malpractice action or persisted in his actions after learning that the physician had done nothing wrong. To overcome a physician's countersuit allegations, all a malpractice plaintiff need show is that he had a reasonable basis for bringing his suit. If malice cannot be proven, the countersuit will fail.[125]

Countersuits by physicians stemming from alleged frivolous mal-

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834, 837 (1965). *See* Luckett v. Cohen, 169 F. Supp. 808, 810 (S.D.N.Y. 1956); Embassy Sewing Stores, Inc. v. Leumi Financial Corp., 39 App. Div.2d 940, 333 N.Y.S.2d 106, 108 (1972). Even if a doctor prevails in a malpractice suit, he does not necessarily prevail in a countersuit. "To justify such a suit you have to show that a reasonable investigation, had one been made, would have disclosed no grounds for complaint in the first place." Reynolds, *How Plaintiff's Attorneys View the Countersuit Tactic,* 53 MED. ECON. 73, 75 (Oct. 4, 1976) [hereinafter cited as Reynolds].

[120] Babb v. Superior Ct., 3 Cal.3d 841, 846-47, 479 P.2d 379, 383-84, 92 Cal. Rptr. 179, 182-83 (1971); McMahon v. May Dept. Stores Co., 374 S.W.2d 82, 90-91 (Sup. Ct. Mo. 1964).

[121] 479 P.2d at 383-84.

[122] *Malicious Prosecution, supra* note 114, at 669. Crescent City Livestock Co. v. Butcher's Union Slaughter-House Co., 120 U.S. 141 (1887); Meints v. Huntington, 276 F. 245 (8th Cir. 1921).

[123] Wilson v. Dunaway, 112 Ga. 241, 144 S.E.2d 542, 545 (1965). *See Malicious Prosecution, supra* note 114, at 669.

[124] Hyde v. Southern Grocery Stores, 197 S.C. 263, 15 S.E.2d 353, 359 (1941); Tanner-Brice Co. v. Barrs, 55 Ga. App. 453, 190 S.E. 676 (1937). In Hunter v. Beckley Newspapers Corp., 129 W.Va. 302, 40 S.E.2d 332, 337 (1946), before an inference of malice could be made, the party bringing the action for malicious prosecution was required to show a lack of probable cause by a preponderance of the evidence.

Any unlawful act done "willfully and purposely to the injury of another" may be proof of malice. Note, *Malicious Prosecution—The Law in Arkansas,* 22 ARK. L. REV. 340, 353 (1968). *See* Smith, *Medical Malpractice: The Countersuit Fad,* 12 TRIAL 44, 46 (Dec., 1976); Carroll v. Kalar, 545 P.2d 411, 412 (Ariz. 1976); Strong v. Roberts & Goldberg, No. 74-2476 (Ct. C.P., Lucas Cty. Ohio, March, 1976).

[125] Reynolds, *supra* note 119, at 75. *See* Konas v. Red Owl Stores, Inc., 158 Colo. 29, 404 P.2d 546 (1965); Wilson v. O'Neal, 118 So.2d 101 (Fla. Dist. Ct. App. 1960).

practice actions have been few. Until recently, no doctor had been successful in a countersuit to a medical malpractice claim.[126] However, in *Berlin v. Nathan*[127] a radiologist brought a successful countersuit against a patient and her attorneys alleging that he was owed a duty not to be involved in malpractice litigation without reasonable cause and that this duty had been violated.[128] The day after the jury for the malpractice action had been selected the plaintiff withdrew her complaint.[129] Subsequently, Mrs. Nathan and her attorneys were found liable for "willfully and wantonly bringing suit against the plaintiff Dr. Berlin, and involving him in litigation without reasonable cause."[130] Mrs. Nathan's attorneys were also found liable for "falling below standards of care required of attorneys to perform their professional duties in good faith and in a legal manner."[131]

The importance of the *Berlin* decision lies not only in the fact that it is the first case in which a doctor succeeded in a countersuit to a malpractice complaint, but also in that it allowed recovery against the patient's attorneys. Generally, an attorney is immune from liability to third persons as long as he does not depart from his role as a quasi-judicial officer who is charged with the responsibility for the

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[126] Berlin, *The Most Important Countersuit Victory Yet*, 53 MED. ECON. 199, 200 (Sept. 20, 1976) [hereinafter cited as *Countersuit Victory*].

[127] Civ. No. 75-M2-542 (Ill. Cir. Ct. Cook Cty., June 1, 1976). In Foster v. McClain, 251 So.2d 179 (La. App. 1971), the physician's countersuit, based on libel, charged that allegations in the plaintiff's complaint were malicious and defamatory. A trial court decision was reversed on the grounds that the physician failed to prove that the plaintiff's complaint had been prepared with malice. *Id.* at 182.

[128] The plaintiff had injured her hand while playing tennis and had come to the hospital for X-rays and treatment. Dissatisfied with the way her hand healed, Mrs. Nathan commenced a $250,000 malpractice suit against the treating doctor, the hospital and the radiologist, Dr. Berlin. Before filing her complaint, Mrs. Nathan had been referred to a well-known hand surgeon who, after examining Mrs. Nathan's hand, opined that the treatment had been correct and that the condition of the hand was not related to the treatment. Mrs. Nathan still proceeded to file her complaint. *Countersuit Victory*, *supra* note 126, at 200-01.

[129] Relating the events leading up to the trial, Dr. Berlin stated that Mrs. Nathan and her attorneys must have been nervous about the countersuit. They offered to withdraw their malpractice suit, if he withdrew his countersuit. Berlin refused. Then Mrs. Nathan and her attorneys proposed to admit to making a false statement in a legal complaint provided that Dr. Berlin waive a demand for payment of a fine. Dr. Berlin again refused. Finally Mrs. Nathan voluntarily withdrew her malpractice complaint. *Id.* at 206.

[130] *Id.* at 211-12, *citing* Berlin v. Nathan, Civ. No. 75-M2-542 (Ill. Cir. Ct. Cook Cty., June 1, 1976).

[131] *Id.* In accordance with the trial court's holding, Dr. Berlin was awarded $6,000 in punitive damages and $2,000 in compensatory damages.

administration of justice.[132] In ethically performing his duties to a client and to the courts, an attorney is required to have a reasonable and honest belief that his client's claim is a valid one for which probable cause exists to initiate suit.[133] The American Bar Association's *Code of Professional Responsibility* provides a set of ethical guidelines for an attorney to follow in his practice.[134] Disciplinary Rule 7-102 proscribes an attorney from filing a suit that is malicious or harassing in character.[135] As long as an attorney abides by the disciplinary rules set forth in the Code, he is immune from liability to third persons in such actions as countersuits to medical malpractice claims.[136] However, if an attorney institutes a proceeding without probable cause or with malice, he loses that immunity and becomes subject to both disciplinary and legal action.[137]

Countersuits by physicians as yet present no real threat to potential malpractice plaintiffs or their attorneys. The requirements of a showing of malice and a lack of probable cause to bring suit are practically insurmountable burdens.[138] The judiciary's general disfavor of countersuits,[139] coupled with these practical difficulties,[140]

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[132] Hoppe v. Klapperich, 224 Minn. 224, 241, 28 N.W.2d 780, 791 (1947). *See* Campbell v. Yellow Cab. Co., 137 F.2d 918 (3rd Cir. 1943); Rosvall v. Provost, 155 N.W.2d 900, 904 (Minn. 1968).

[133] Tool Research & Eng.'s Corp. v. Henigson, 46 Cal. App.3d 675, 120 Cal. Rptr. 291, 297 (1975).

[134] The effectiveness of the ABA CODE OF PROFESSIONAL RESPONSIBILITY lies in its strict enforcement by the legal profession. *See* ABA SPECIAL COMM. ON EVALUATION OF DISCIPLINARY ENFORCEMENT: PROBLEMS & RECOMMENDATIONS IN DISCIPLINARY ENFORCEMENT (1970).

[135] DR 7-102 (A)(1) of the ABA CODE OF PROFESSIONAL RESPONSIBILITY states:

> [a] lawyer shall not: file a suit, assert a position, conduct a defense, delay a trial, or take other action on behalf of his client when he knows or when it is obvious that such action would serve merely to harass or maliciously injure another.

[136] *Malicious Prosecution, supra* note 115, at 671.

[137] *Id.* at 671-72.

[138] *See* text accompanying note 125 *supra.*

[139] *See* note 113 *supra.*

[140] In addition to the difficulties a physician has in meeting his burden of proof in a countersuit, *see* text accompanying notes 116-125 *supra,* the physician may also be subject to a counter-counter-suit if his own suit fails. Reynolds, *supra* note 119, at 76. Further, even if a physician prevails in a countersuit, his suit may have cost him more than he can collect. The problem lies in proving damages. In a malpractice action a patient's injuries may be obvious, whereas in a countersuit the physician's injuries, which may be limited to loss of professional reputation or mental anguish, are obscure. *Malicious Prosecution, supra* note 115, at 655-56. Finally, there is a general reluctance among attorneys to handle countersuits. This arises in part from low anticipated countersuit recoveries and from a "conspiracy of silence" toward going against a fellow

makes the countersuit a relatively ineffective means of limiting the number of medical malpractice suits. Nevertheless, awareness that a countersuit is available to a physician who believes he has been maliciously prosecuted may prevent the filing of claims that have not been adequately searched and prepared.[141]

Considering the seriousness and continued existence of a medical malpractice crisis,[142] statutes limiting damages, and countersuits by physicians do not provide the solution to the problem. Not only do these two alternatives fail to fulfill the desire of the medical community to decrease malpractice actions, but more importantly, they do not satisfy those patients who have been injured by a negligent physician.

Statutes limiting damages are meant to ease the burden of rising malpractice insurance rates, but in attempting to do so they have placed arbitrary ceilings for recovery on those patients who are seriously injured.[143] Not only do these statutes present practical problems for malpractice litigants, but they are subject to attacks on their constitutionality.[144] Countersuits by physicians are a novel approach to the growing number of medical malpractice cases, although they have so far proved impractical. General disfavor by the judiciary, the difficult burden of proof, and low anticipated recoveries do not provide a good foundation for successful countersuits.[145]

The resolution to the medical malpractice crisis lies within the medical and legal professions themselves. A greater awareness and cooperation between the two professions will help to decrease malpractice actions in which attorneys with no medical expertise pass judgment on elements of diagnosis and treatment.[146] One method of

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attorney who conducted the medical malpractice action. Reynolds, *supra* note 119, at 77.

[142] Berlin v. Nathan, Civ. No. 75-M2-542 (Ill. Cir. Ct. Cook Cty., June 1, 1976) presents an example of a claim that was not adequately researched. Mrs. Nathan's complaint against Dr. Berlin included an allegation that he had improperly handled X-rays before they had dried. In fact, the hospital used automatic film processing which made it impossible to handle a wet X-ray. Mrs. Nathan and her attorneys admitted that they had not researched the basis for their allegations against Dr. Berlin. *Countersuit Victory*, *supra* note 126, at 201.

[142] More than 20,000 malpractice claims are brought each year, and that figure is increasing. NEWSWEEK, June 9, 1975 at 59.

[143] *See* text accompanying notes 14-45 *supra*.

[144] *See* text accompanying notes 43-45 *supra*.

[145] *See* text accompanying notes 139-142 *supra*.

[146] Frankel, *Medico-Legal Communication*, 6 WILLAMETTE L. J. 193, 193 (1970). *See* Eaton, *The Need for Mutual Understanding in the Legal and Medico-Scientific Professions*, 8 MEDICINE, SCIENCE AND THE LAW 78 (1968).

providing cooperation between the two professions is through the use of review panels. Malpractice review panels are theoretically designed to use experts from both professions to eliminate frivolous actions and assist in trial preparation. If the legal profession recognizes the problems that confront review panels and makes a genuine effort to work with physicians to alleviate these problems, the panels may succeed in providing stop-gap relief to the medical malpractice crisis. However, review panels will not provide curative relief for the difficulties inherent within our anachronistic system of health care delivery that have manifested themselves through a malpractice crisis. In addition to the need for cooperation between the medical and legal professions, the medical profession itself will have to take an active role in self-regulation to insure that those physicians who practice in a careless manner are properly disciplined and not allowed to jeopardize the health of those who are in need of medical treatment.[147] A successful campaign of self-regulation might preclude the need for damage-limiting statutes, countersuits and review panels.

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[147] LEGISLATOR'S GUIDE, *supra* note 10, at 75.