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The Medical Malpractice Crisis: Is the Medical Review Committee a Viable and Legal Alternative?

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THE MEDICAL MALPRACTICE CRISIS: IS THE MEDICAL REVIEW COMMITTEE A VIABLE AND LEGAL ALTERNATIVE?

INTRODUCTION

The concept of medical malpractice recently has been the subject of intense discussion in the nation's newspapers, magazines and legal periodicals. Perhaps the principal reason for the increased interest in this subject is the tremendous rise in the number of medical malpractice lawsuits during recent years. It has been estimated that the number of malpractice claims increased ten-fold between 1930 and 1940 and another ten-fold between 1940 and 1950. In addition, there has been a significant increase in claims from 1950 to 1970. And, in the last five years, it is estimated that nationwide the number of malpractice suits has doubled to 20,000 per year.

The increase in the number of malpractice suits filed in Northern California has been especially pronounced. Insurance experts state that 267 malpractice suits were filed against physicians in Northern California in 1967, and the number had risen to 477 by 1972.

Not only has the number of malpractice suits increased, but the damages awarded in such suits have also risen substantially. In 1973, for example, a San Francisco jury awarded $4,025,000

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2. AMERICAN TRIAL LAWYERS ASSOCIATION, MEDICAL MALPRACTICE—THE ATL SEMINAR 31 (1966).

3. See SENATE SUBCOMMITTEE ON EXECUTIVE REORGANIZATION, 91st CONG., 1ST SESS., A STUDY ON MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN (Comm. Print 1969). For example, a Cleveland defense attorney, in testifying before the Senate subcommittee investigating medical malpractice, estimated that the number of malpractice suits he has defended increased 400 percent between 1955 and 1966. In addition, a representative of the Aetna Life and Casualty Company, in testifying before the same committee, stated that the number of malpractice claims increased 43 per cent between 1965 and 1969. Id. at 8.


6. Id.
to a paralyzed boy in a suit against a physician and a hospital.  
In addition, two other malpractice suits brought in Northern California were recently settled out of court—one for $2 million and the other for $1.3 million.

This comment will survey the responses of the malpractice insurers to this medical malpractice crisis. It focuses on the operation and effectiveness of one of those responses—the malpractice screening committee. The validity of the malpractice screening committee was recently scrutinized by the California Court of Appeal in the case of Garner v. American Mutual Liability Insurance Co.  
In that case the court held that the malpractice insurer must itself consider and determine whether or not to accept a settlement offer and cannot delegate such a decision to a medical screening committee. This comment examines the Garner decision in light of current California law, and discusses the effects of that decision on California physicians and their insurers.

Responses to the Malpractice Crisis

In response to the rise in the number of malpractice cases and the significant increase in the damages awarded in such suits, many companies have discontinued underwriting medical malpractice insurance. At present, only five companies still provide this type of protection for doctors, and most of these companies have found the decision to remain in the malpractice business a difficult one.

The companies which have continued to provide professional liability insurance to physicians have instituted a number of measures to deter the filing of baseless malpractice suits and to assure the continued availability of malpractice insurance. The most important measures implemented by these malpractice insurers have been (1) an increase in the premiums for malpractice coverage, (2) the establishment of peer review committees to determine which physicians are good insurance risks, and (3) the creation of panels to review malpractice claims.

Increased Malpractice Insurance Premium

In an attempt to meet the rising cost of malpractice litigation, insurance carriers have increased dramatically their insurance.
premiums. Between 1960 and 1970, premiums for physicians who do not perform surgery rose 540.8 percent, while for surgeons the increase was an astounding 949.2 percent. An insurance broker recently stated that in the San Francisco Bay Area maximum coverage against malpractice claims will cost an internist who performs no surgery up to $4,000 per year, while surgeons and anesthesiologists may pay nearly $10,000 per year for their malpractice coverage. In Michigan and Texas, some surgeons pay annual premiums in excess of $20,000 for similar coverage.

Perhaps the most startling statistic involving malpractice insurance rates is the proposed 1975 premium of $43,000 to be required of New York neurosurgeons and orthopedists. This incredible sum contrasts with the 1965 premium of $819 and the 1974 premium of $14,000 paid by the same physicians.

Peer Review Committees

Another measure taken by the malpractice insurers to deal with the malpractice crisis has been to encourage local medical societies which have group malpractice insurance policies to establish peer review committees. The purpose of the peer review committees is to determine which physicians in the local area have demonstrated a high level of professional competence and are, therefore, good risks for a malpractice insurer. In making determinations as to whether a physician is a good insurance risk, the committee usually looks to three factors: (1) the quality of the physician’s work, (2) the number of malpractice claims previously brought against the physician, and (3) the number and amount of any settlements obtained and/or judgments rendered against the physician.

Physicians who are classified by the committee as bad risks frequently will not be able to obtain malpractice insurance under

12. HEW, REPORT OF THE SECRETARY’S COMMISSION ON MEDICAL MALPRACTICE, MEDICAL MALPRACTICE 13 (1973) [hereinafter cited as COMMISSION ON MEDICAL MALPRACTICE].
14. Id.
17. Id.
18. Telephone interview with Dr. Frank J. Boutin, member of Sacramento County Medical Review Committee, Sept. 7, 1974.
19. Id.
20. Id.
the local medical society's group insurance policy. If insurance coverage is extended, the insurance premiums will be increased significantly, or the insured will be required to assume a large deductible amount.

**Screening Panels**

Reacting to the significant increase in the number of malpractice claims, insurance companies and physicians also have established screening panels to review these claims. At the present time there are four major types of screening panels: the medical-legal screening panel, the court-sponsored screening panel, the statutory screening panel, and the physician screening panel. All of the panels share in varying degrees the common goal of encouraging the settlement of meritorious claims and the abandonment of claims which, in the particular panel's judgment, are not supported by sufficient evidence of professional negligence to merit a lawsuit for malpractice. It is important to note that none of the panels determines the merits of the claims with finality as would arbitration of a malpractice action.

**Medical-legal screening panel.** One type of screening committee utilized in some areas is the medical-legal screening panel. Such a panel has been established in Pima County, (Tucson), Arizona. The Pima County panel is composed of both doctors and lawyers who serve on a voluntary basis. There are two fifteen-member committees in Pima County which actively review malpractice claims. One of the committees is appointed by the County Medical Association and the other by the local Bar Association. When a request for a hearing is presented to the chairman of either committee by either the plaintiff or the defendant-doctor—and if both sides then agree to a hearing—the chairmen of the two committees select seven doctors and seven attorneys to hear the case. In addition, the chairmen appoint a physician to assist the claimant in preparing his or her case for the panel. No charge is imposed on the claimant for the assistance he or she receives from the physician.

21. Id.
22. Id.
23. Are Malpractice Screening Panels the Answer? *Medical Economics* 106 (Mar. 1, 1971) [hereinafter cited as *Malpractice Screening Panels*].
25. Id.
27. Id.
28. Id.
29. Id.
30. Id. at 120.
31. Id.
When the panel has heard the case and made its decision, both sides are expected to abide by it; neither side, however, is legally bound by the committee's decision. In the vast majority of cases the parties accept the decision of the screening panel. Statistics indicate that even when a plaintiff is confronted by an unfavorable decision, he rarely pursues his case in court; and, when the panel finds in favor of the plaintiff, the physician and insurer invariably settle.

Proponents of the medical-legal screening panel contend that it offers numerous advantages. They argue that the panel keeps the physician's name out of the newspapers and keeps the physician out of the courtroom. Proponents also urge that review by the panel is objective and aids in the disposition of malpractice claims. In addition, it is argued that since the medical-legal review committee provides expert witnesses to plaintiffs, it ends the so-called conspiracy of silence whereby physicians refuse to testify against their colleagues who are defendants in malpractice cases. Finally, these proponents claim that the medical-legal review committee has been successful in decreasing the number of malpractice suits filed.

It should be noted that the medical-legal review committees also have been the subject of considerable criticism. Critics of the medical-legal panels contend that they are too "plaintiff-oriented," and that too many cases are decided against the physician. In addition, it is argued that if the panel decides that a malpractice complaint has merit, the plaintiff invariably demands a settlement twice as large as the damages warrant. Further, so the critics contend, since such panels have not been models of cooperation between the medical and legal professions, the effectiveness of the medical-legal panel has suffered. Finally, critics of the medical-legal review committee argue that the panels are ineffective inasmuch as they have not stabilized the cost of malpractice insurance.

Court-sponsored screening panel. Two jurisdictions, New Jersey and New York, have established screening panels which,
unlike the medical-legal review committees, are administered under state court systems. The New York panel operates as a pre-trial mediation board with a judge, physician, and lawyer encouraging the parties to settle. In New Jersey, both the claimant and the physician exercise some control over the operation of the panel. Prior to the review of his claim, the claimant enters into an agreement with the screening panel under which he promises not to pursue his case in court, if the panel finds no evidence of malpractice. In return, the medical society will provide an expert witness for the plaintiff, should the panel find for the claimant. The defendant-physician similarly exercises control over the operation of the review panel, in that no review hearing may be held without his consent.

Statutory screening panel. Only New Hampshire has established a statutory screening panel. Under the New Hampshire plan, claims against physicians (and dentists and lawyers) are heard by a three-member panel composed of one judicial officer, one member of the public, and one physician. Unlike other screening panels, the New Hampshire panel not only determines the issue of liability but also ascertains with particularity money damages. However, the finding as to the appropriate amount of money damages is only advisory; the parties are free either to accept the finding of the panel, or to reject it and bring suit.

Physician screening panel. The fourth type of malpractice screening committee is that which is composed entirely of physicians. More malpractice claims are brought before this type of screening panel than any other review committee. In California, physician screening panels now exist in more than twenty counties. It is estimated that 11.1 percent of malpractice claims nationwide are currently brought before physician panels. In contrast, the highly-publicized medical-legal screening panels review only 1.9 per cent of all malpractice claims.

The purposes of the physician screening panel serve two functions. First, the panel determines whether the defendant-

42. Commission on Medical Malpractice, supra note 12, at App. 225.
43. Id.
44. Id.
45. Id.
46. Id.
47. Id.
48. Id. at 225-26.
49. Id. at 227.
50. Id.
52. Commission on Medical Malpractice, supra note 12, at App. 225 n.5.
53. Id. at n.7.
MEDICAL MALPRACTICE

55. Id.
56. Telephone interview with Dr. Frank J. Boutin, member of Sacramento County Medical Review Committee, Sept. 7, 1974.
57. Id.
58. Id.
59. Id.
60. Id.
acceptability of a settlement offer to a medical review committee. 62

THE GARNER DECISION

The Facts

American Mutual Liability Insurance Company issued a group medical malpractice insurance policy to the Sacramento County Medical Society, under which individual doctors could buy malpractice coverage for the amount they desired and the premium they were willing to pay. In accordance with the terms of that policy, plaintiff-physician (defendant in the underlying malpractice action) was insured for a maximum of $100,000.

While the policy was in effect, Dr. Garner treated a woman patient who died under his care. Her heirs sued Dr. Garner for malpractice. Since Dr. Garner's insurance carrier (American Mutual) refused on the advice of Sacramento's Medical Review Committee to settle the case, the malpractice claim went to trial. The jury rendered a $225,000 judgment against the physician ($125,000 over his policy limits), and he proceeded to file an excess judgment action against American Mutual. In this action the trial court rejected Dr. Garner's allegation that American Mutual had acted in bad faith in refusing to settle within the policy limits, and rendered judgment for the insurance company. On appeal, the appellate court reversed the trial court and directed that judgment be entered in favor of the plaintiff on the issue of the insurer's liability. 63

The Holding and Reasoning

The court of appeal held that American Mutual had committed a breach of duty for failing to accept or initiate reasonable settlement offers within the policy limits. 64 In reaching its conclusion, the court first noted that in California there is an implied covenant of good faith and fair dealing in every liability insurance policy, which includes the duty to accept settlement offers under certain conditions. 65 Moreover, this duty requires that the insurer

62. Id. at 849, 107 Cal. Rptr. at 608.
63. Id. at 851, 107 Cal. Rptr. at 609.
64. Id. at 849, 107 Cal. Rptr. at 608.
65. Id. at 847, 107 Cal. Rptr. at 606-07. The Garner court cited a number of cases which establish this proposition: Shapero v. Allstate Ins. Co., 14 Cal. App. 3d 433, 438, 92 Cal. Rptr. 244, 247 (1971), in which the court affirmed a judgment for the defendant-insurance company in an action by an insured against his insurer for damages arising from the insurer's failure to settle a claim within the policy limits; Hodges v. Standard Accident Ins. Co., 198 Cal. App. 2d 564, 574, 18 Cal. Rptr. 17, 23 (1961) in which the court held that the evidence
itself consider and determine whether or not a settlement offer is in the best interest of the insured. Because American Mutual delegated exclusive authority to the Medical Review Committee to determine whether or not to settle the case, it was held to have breached its duty vis-a-vis Dr. Garner. Thus, the Garner court found that American Mutual's reliance upon the recommendation of the Medical Review Committee resulted in an inadequate consideration of the non-medical aspects of the case (such as the appearance and effect upon the jury of the parties and witnesses) and a deprivation of the protection, to which Dr. Garner was entitled, from American Mutual's total experience and expertise in claims evaluation.

The validity of these conclusions is questionable. The former determination is suspect because it is clear that the review committee had made a good faith and intelligent consideration of the case, as is required by California case law. The latter conclusion is equally unpersuasive because the review committee procedure assures that the past experiences of the insurer in evaluating malpractice claims will be drawn upon in determining whether or not to settle.

CRITIQUE OF THE COURT'S RATIONALE

Duty of Insurer to Settle

It is well established in California that although an insurance policy contains an express statement only of the insurer's duty to defend, the insurer has an implied obligation to accept a reasonable settlement designed to absolve its insured of further liability to a third party. This duty to accept a reasonable offer of settlement is implied in the covenant of good faith and fair dealing

would not sustain findings of bad faith on the part of the insurer in not accepting a settlement offer; and Brown v. Guar. Ins. Co., 155 Cal. App. 2d 679, 689, 319 P.2d 69, 75 (1957) in which the court reversed a judgment for defendant-insurance company where the insurer unreasonably refused to accept a settlement offer in an action against the insured.

66. 31 Cal. App. 3d at 848, 107 Cal. Rptr. at 607.
67. Id. at 850, 107 Cal. Rptr. at 608-09.
68. Id. at 849, 107 Cal. Rptr. at 608.
69. See text accompanying notes 81-84, infra.
70. See text accompanying note 90, infra.
which exists in every insurance contract.\textsuperscript{72} Violation of this duty of the insurer sounds in tort, and an insured may recover for all detriment resulting from such violation.\textsuperscript{73} In the Garner case the key issue was whether the insurance company acted in good faith in refusing to settle the case brought against Dr. Garner.

The traditional test of whether an insurance carrier acted in good faith in refusing to settle a case is set forth in Crisci v. Security Insurance Co.\textsuperscript{74} In that case the California Supreme Court held that the test of good faith is "whether a prudent insurer without policy limits would have accepted the settlement offer."\textsuperscript{75} In Garner, the trial court found that a prudent insurer would not have accepted the plaintiff's settlement offer regardless of the limits of Dr. Garner's policy.\textsuperscript{76} Although the determination of this issue is solely within the province of the trier of fact\textsuperscript{77} (in this case, the trial court), the court of appeal refused to recognize the lower court finding.

In addition to the test set forth in Crisci, California cases have utilized several other tests to determine whether an insurer has breached his duty to act in good faith. For example, in Brown v. Guarantee Insurance Co.,\textsuperscript{78} the court recited the following factors to be considered in deciding the issue of good faith:

\[\text{[T]he strength of the injured claimant's case on the issues of liability and damages; attempts by the insurer to induce the insured to contribute to a settlement; failure of the insurer to properly investigate the circumstances so as to ascertain the evidence against the insured; the insurer's rejection of advice of its own attorney or agent; failure of the insurer to inform the insured of a compromise offer; the amount of financial risk to which each party is exposed in the event of a refusal to settle; the fault of the insured in inducing the insurer's rejection of the compromise offer by misleading it as to the facts; and any other factors tending to establish or negate bad faith on the part of the insurer.}\]


\textsuperscript{74} 66 Cal. 2d 425, 426 P.2d 173, 58 Cal. Rptr. 13 (1967).

\textsuperscript{75} Id. at 429, 426 P.2d at 176, 58 Cal. Rptr. at 16.


\textsuperscript{78} 155 Cal. App. 2d 679, 319 P.2d 69 (1957).

\textsuperscript{79} Id. at 689, 319 P.2d at 75.
Although this is a comprehensive set of rules, it clearly is not a workable test for good faith.

A more functional test of whether an insurance company exercised good faith in refusing to settle a case is found in Palmer v. Financial Indemnity Co. In Palmer, the court noted that the exercise of good faith requires that the consideration given to the offer of settlement should be an intelligent one, should be based on a reasonable investigation, and should be made by persons reasonably qualified to make a decision respecting the risks involved.

If the Garner court had applied this test, its decision might have been different.

First, the evidence in the case indicates that the Medical Review Committee made a good faith and intelligent consideration of the offer to settle the malpractice case brought against Dr. Garner. The Committee carefully considered the merits of the case against the physician on two separate occasions and each time it unanimously found that Dr. Garner had committed no malpractice.

Second, the investigation made by the insurance carrier and the Medical Review Committee was adequate. Two lawyers were assigned to represent Dr. Garner and they utilized numerous discovery tools in preparation for trial. In addition, since the trial court found that American Mutual had not acted in bad faith in refusing to settle the case, it can be inferred that the company had in all probability conducted a reasonably complete investigation of the case against Dr. Garner.

Finally, it seems clear that a group of distinguished physicians sitting on a review committee is "reasonably qualified" to determine whether a particular malpractice claim is meritorious. The Garner court, however, did not think that such a group was sufficiently qualified to make the final decision on whether to settle. The court decided that the Committee's decision-making process did not allow for due consideration of the strengths and weaknesses of the case as it would be presented at trial. In addition, the court noted that by giving the Medical Review Committee sole power to determine whether to settle, the insured was
precluded from receiving the benefit of American Mutual's experience and expertise in claims evaluation. 86

These criticisms are not persuasive in light of the fact that the Medical Review Committee was organized to handle these specific types of problems. The insurance carrier's trial counsel may refer a case back to the Medical Review Committee for further evaluation if, during the trial, new evidence appears or a concern develops over the strength of the defendant-physician's case. 87 If the Medical Review Committee finds evidence of malpractice upon re-evaluation, it may recommend a settlement. 88 In the Garner case, nothing occurred during the trial to mitigate Dr. Garner's counsel's conviction that his client had not committed malpractice; thus the case was not returned to the committee for a further evaluation. 89 Viewed in this light, the Garner court's criticism that the committee never considers the merits of a case as it is presented at trial is unfounded.

To guarantee that the insured receives the benefit of the insurer's experience in claims evaluation, insurance company officials, including the insurer's attorneys, its manager of local operations, investigators and claims adjusters, attend all Medical Review Committee hearings. 90 Thus, representatives of the insurance carrier are able to consider all medical and legal aspects of a particular malpractice claim, thereby assuring that the insurer's expertise will be utilized in deciding whether or not to settle.

In reaching its decision that American Mutual had breached its duty of good faith to Dr. Garner, the Garner court ignored two important California cases, Hodges v. Standard Accident Insurance Co. 91 and Marsango v. Automobile Club of Southern California. 92

In Hodges, the plaintiff brought an action against his insurance company to recover the amount of a personal injury judgment rendered against him in excess of the limits of his automobile liability policy ($10,000). The plaintiff alleged that the insurance company had acted in bad faith by refusing to settle the personal injury action for the sum of $5,000 prior to the time of the judgment, which was $35,721.20 (later reduced by the court

86. Id.
88. Id.
89. Id.
90. Telephone interview with Dr. Frank J. Boutin, member of Sacramento County Medical Review Committee, Sept. 14, 1974.
to $27,721.20). At trial, the court gave judgment in favor of the plaintiff and against the insurance company in the amount of the excess personal injury judgment. The court of appeal reversed the trial court's finding that the insurance company had acted in bad faith in refusing to settle. The court found the trial court's ruling erroneous because (1) the insurer's attorney felt that even if the plaintiff (defendant in the underlying personal injury action) were found liable, the case was worth much less than the plaintiff's policy limits, and (2) the insurer's attorney believed that it was a "50-50 case for liability."

In Marsango, the plaintiff had originally obtained a personal injury judgment in excess of the defendant's insurance policy limits. The plaintiff, as an assignee of the original defendant (insured) in the personal injury action, thereupon filed suit against the defendant insurer. The plaintiff alleged that the insurer had acted in bad faith because, prior to the time of the $90,000 judgment rendered in the personal injury action, it had refused to settle the case for a sum within the insured's policy limits. The trial court held that the insurer had not acted in bad faith and the appellate court affirmed. The court of appeal found that the insurer's experienced trial counsel had determined, on the basis of the facts developed in the preparation of the case, that the insured would incur no exposure beyond the policy limits. Therefore, the court held that there did not exist such a great risk of recovery beyond the policy limits as to have required the insurer to settle out of consideration for the interest of the insured.

A close examination of the facts in Garner reveals that the factors relied upon by the courts in Hodges and Marsango were also present in the Garner case. First, the counsel assigned by American Mutual to defend Dr. Garner determined, on the basis of a careful and conscientious evaluation of the case against the physician, that no verdict would be returned against him. In addition, the attorneys believed that even if the jury were to find Dr. Garner liable, the judgment rendered against him would not exceed his policy limits.

In addition to the factors present in Hodges and Marsango, there existed in Garner two other elements which made it reason-

93. 198 Cal. App. 2d at 567, 18 Cal. Rptr. at 18.
94. Id. at 574-75, 18 Cal. Rptr. at 23-24.
96. Id. at 696, 82 Cal. Rptr. at 97.
97. Id. at 697, 82 Cal. Rptr. at 97.
99. Id.
able for American Mutual to anticipate that a verdict against Dr. Garner, if rendered, would not exceed the physician's policy limits. First, since the Medical Review Committee had found that Dr. Garner had committed no malpractice in treating the deceased patient, the insurer could reasonably conclude that no verdict would be rendered against its insured. Second, Dr. Garner's counsel believed that if any verdict were rendered against the doctor, the other defendant, a local hospital, would also have been held liable. Thus the counsel thought that any judgment awarded to the plaintiff would be reduced by half, insofar as Garner himself was concerned.

In essence, the Garner court adopted a new, hindsight approach for determining whether an insured breached its duty to act in good faith in refusing to settle an action against its insured. It is clear, of course, that American Mutual's decision not to settle was unfortunate for Dr. Garner and the company. However, the mere fact that the insurer's decision was unfortunate and incorrect (in the sense that a verdict was returned in excess of the insured's policy limits) does not necessarily support the conclusion that the company breached its covenant of good faith and fair dealing. Moreover, it is well-established by California case law that the question whether a course of conduct was proper cannot be decided on the basis of hindsight. Unfortunately, the Garner court seems to have ignored this important principle of California law.

Contracts of Adhesion and Contracts Against Public Policy

The Garner holding also appears to run counter to basic principles of contract law. The decision ignores the fact that in agreeing to be insured by American Mutual, Dr. Garner approved the policy's provision that no claims would be settled by the insurance carrier without a hearing by the Medical Review Committee to determine whether the physician had committed malpractice. Such a provision should be binding on both parties, unless the insured can show that the term was in some way contrary to public policy or that it transformed the policy into a contract of adhesion.

Relevant California case law probably would not support a

finding that American Mutual's insurance policy was unconscionable for either reason. It is well established that a contract of adhesion is a contract drafted by the party of superior bargaining power, prepared without serious negotiations between the parties, and used in all dealings relating to the product or service the stronger party offers. Although American Mutual might have been in a superior bargaining position vis-a-vis the Medical Society which negotiated Dr. Garner's malpractice insurance policy, the other two elements essential to an adhesion contract were not present in Garner's contract. First Dr. Garner's insurance policy was negotiated by the Sacramento County Medical Society on behalf of Garner and the other society members. In such negotiations, the terms and conditions of the policy were the subject of intense negotiations between American Mutual and the Medical Society. The medical review provision was forced upon neither the Medical Society nor its member physicians, including Dr. Garner. To the contrary, the inclusion of the crucial medical review provision was insisted upon by the vast majority of the Medical Society's members. In addition, the trier of fact determined that Dr. Garner had fully concurred in and approved the policy under which American Mutual reserved the right to refuse to settle a case in which the Medical Review Committee concluded that there had been no malpractice.

As noted above, another characteristic of most adhesion contracts is that the contract form, or one of its provisions, is used in all dealings relating to the product or service the stronger party offers. This element was not present in Dr. Garner's contract of insurance with American Mutual. The medical review provision in Garner's policy is not included in all of American Mutual's malpractice insurance policies, and it was included only at the request of the Sacramento County Medical Society.

The Garner court also seemed to overlook the fact that the

105. Id.
106. Telephone interview with Dr. Frank J. Boutin, member of Sacramento County Medical Review Committee, Sept. 14, 1974.
Sacramento County Medical Society was the "named insured" in the policy issued by American Mutual. In accordance with the terms of that policy, any doctor who was a member of the Society could become an insured under the policy. However, unlike most adhesion contract situations, no doctor, including Dr. Garner, was required to carry insurance through American Mutual. In fact, 20 to 22 percent of the physicians in the Sacramento area are not insured under the Medical Society's malpractice insurance policy. It is therefore probable that Dr. Garner could have acquired insurance from one of the other three malpractice insurers in the Sacramento area, and thereby could have avoided American Mutual's requirement that all malpractice claims be evaluated by a medical review committee.

It is also clear that the medical review committee provision in Dr. Garner's insurance contract was not contrary to public policy. In Steven v. Fidelity & Casualty Co. it was held that certain portions of an airline insurance policy were void as against public policy. The California Supreme Court noted in that case that the question of whether a particular contractual provision is against public policy should be examined in light of the purpose and intent of the parties in entering into the contract, the insured's knowledge and understanding of the policy as a reasonable layman, and the insured's normal expectation of the extent of the policy's coverage. Applying this test to the American Mutual policy insuring Dr. Garner, it is reasonable to conclude that the medical review provision was not against public policy. Dr. Garner entered into the contract with American Mutual with the understanding and expectation that malpractice suits would be settled by the insurer only after the Medical Review Committee had reviewed the case and determined that it had merit. No public policy militates against the formation of a contract by parties who are free to bargain for and are able to understand its terms. It is significant that the Garner decision constituted a break from established precedent upholding the right of individuals freely to negotiate and carry out such a contract.

110. Telephone interview with Mr. William Dochtermann, Executive Director, Sacramento Medical Society, Sept. 4, 1974.
111. Id.
112. Id.
114. Id. at 869, 377 P.2d at 288, 27 Cal. Rptr. at 176.
EFFECTS OF THE GARNER DECISION

Deterring the Filing of Baseless Claims and Encouraging the Settlement of Meritorious Claims

Through the establishment of medical review committees, physicians and malpractice insurers have made a viable attempt to handle malpractice cases more efficiently and equitably. Although the medical review committee is not a panacea, it appears to be a successful means of "weeding out" malpractice claims which lack merit and of encouraging settlement of claims that are meritorious. In most cases, when the review committee finds evidence of malpractice, the insurance company readily enters into a settlement with the plaintiff.\textsuperscript{110} In contrast, when the committee determines that a physician has not committed malpractice, this finding usually indicates to the plaintiff that his case is legally weak.\textsuperscript{117} Since in the past there has been a high correlation between the medical review committee’s decisions and jury verdicts, a decision by the committee that a physician has committed no malpractice often convinces the plaintiff not to prosecute his case further.

A recent statistical analysis of the cases brought against physicians insured by American Mutual and reviewed by medical review committees indicates the strength of this assertion. For example, 46 percent of the cases brought before the medical review committees were never pressed to trial and the insurer made no payments in settlement of the claims, because the committees found that there had been no malpractice.\textsuperscript{118} In contrast, 33 percent of the cases reviewed by the committees were settled, because the panels concluded that there had been some malpractice on the part of the defendant-physician.\textsuperscript{119} Thus, on the basis of the committees' findings, nearly 80 percent of the cases which were reviewed by the committees did not go to trial. In the remaining 20 percent of the cases, although the panel found no evidence of malpractice, the plaintiff chose to go to trial.\textsuperscript{120} Of the cases actually tried, 85 percent resulted in verdicts for the insured, while only 15 percent were resolved in favor of the plaintiff.\textsuperscript{121}

The conclusion is inescapable: the medical review committee has proved to be an effective tool in the evaluation of medi-
cal malpractice claims. Unfortunately, the Garner decision may diminish the effectiveness of the medical review committee and thereby impair the ability of the committee to deter the filing of baseless claims and to encourage the settlement of those that are meritorious.

**Alternative to Trial**

Insurers and physicians have attempted to provide, through the creation of medical review committees, an alternative to lengthy and expensive malpractice trials. It appears that the Garner decision may impair their efforts to provide such an alternative.

Prior to Garner, when the Sacramento County Medical Review Committee evaluated a malpractice claim and found it to be meritorious, the case usually was promptly settled and the plaintiff avoided long delays in obtaining compensation for his claim. The committee's determination that a physician had deviated from the standard of care in the community caused the insurer readily to settle the case. Thus, the Medical Review Committee provided the plaintiff whose claim was legitimate a viable alternative to a long, arduous trial. However, as a result of the Garner decision, the findings of the review committee no doubt will carry less weight with the malpractice insurer. A committee's finding that there has been malpractice will no longer guarantee that the insurance company will make strenuous efforts to settle the case. Thus, it is ironic that although the Garner decision purports to encourage settlement of malpractice cases, the actual result may be that fewer cases will be settled.

**Nuisance Suits**

According to the chairman of the Medical Review Committee of the Sacramento Medical Society, another possible effect of the Garner decision is an increased pressure on insurers to settle nuisance malpractice cases. The chairman contends that Garner creates a new, amorphous test for deciding whether an insurance company has acted in good faith in refusing to settle

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122. Telephone interview with Mr. William Dochterman, Executive Director, Sacramento County Medical Society, Sept. 4, 1974.
124. Sheridan, *Malpractice: Can they force you to stand trial?*, MEDICAL ECON. 73, 78 (June 24, 1974) [hereinafter cited as Stand Trial]. A nuisance suit is one in which the plaintiff's claim is highly suspect, but in which the cost of defense is substantially in excess of the claim.
a malpractice claim against an insured physician. In addition, another proponent of the medical review committee argues that the case propounds the theory that, in deciding whether to enter into a settlement with a plaintiff, the emotional factors of a case (the plaintiff's appearance and appeal to the jury) are more important than an honestly arrived-at, good faith decision that there was no malpractice.

Traditionally, the insured physician has been reluctant to settle a case of dubious merit for fear of ruining his reputation as a competent doctor. In contrast, the malpractice insurer, prior to the advent of the medical review committee, was more inclined to settle doubtful claims because of its desire to minimize the cost of disposing of the case. With the advent of group insurance and the creation of the medical review committee, however, the malpractice insurers became less inclined to settle dubious claims, which resulted in the filing of fewer nuisance suits. By employing the review committee, local physicians were able to advise the insurer as to whether or not a physician sued for malpractice had breached the standard of care of the community. By accepting such advice, the insurer was confident in the correctness of its decision to settle or not to settle a case. However, if the result of the Garner decision is that the judgment of the medical review committee is to be disregarded, review committee proponents contend that malpractice suits will be brought "in the hope that a doctor's fears of the trauma of going to court will lead to an unwarranted settlement."

Increased Premiums

As noted above, the Garner decision is likely to lead to a less effective—or non-existent—medical review committee, and thus to an increase in the filing and prosecution of unfounded malpractice claims. As a result of this increase, physicians' malpractice insurance premiums undoubtedly will continue to rise at a rapid pace. Unfortunately, these premium increases will most certainly be passed on to the patient. Indeed, at the present time, as much as five per cent of a patient's total fee goes to pay the

125. Id. at 79.
126. Statement of William E. Scheuber, Executive Secretary of the Alameda-Contra Costa Medical Association. Id.
127. Id. at 78.
128. Id.
129. Id.
130. Id.
131. Id. at 78-79.
132. See text accompanying notes 122-24 supra.
133. COMMISSION ON MEDICAL MALPRACTICE, supra note 12, at 12.
physician’s malpractice insurance premiums.\textsuperscript{134}

In addition, the cost of malpractice insurance may be driven up because the \textit{Garner} case tends to undercut the ability of insurance companies to provide malpractice coverage at lower premium rates.\textsuperscript{135} Prior to \textit{Garner}, some malpractice insurers (including American Mutual) required a physician seeking professional liability insurance coverage to be bound by the decisions of the medical review committee. Proponents of the medical review committee contend that this requirement ultimately resulted in a reduction of baseless claims, and consequently minimized the increase in the cost of malpractice insurance.\textsuperscript{136} Unfortunately, the \textit{Garner} decision limits the right of the insurance company to include such a requirement in its malpractice insurance policies. It appears that this limitation may have already resulted in an increase in the cost of malpractice premiums.\textsuperscript{137}

Although some malpractice insurance carriers have chosen to increase their premiums, others have abandoned entirely their efforts to provide malpractice coverage.\textsuperscript{138} This unfortunate result is demonstrated by American Mutual's recent decision to withdraw from the medical liability field.\textsuperscript{139} Similarly, another major medical malpractice insurer in California recently announced that it was canceling its malpractice policies.\textsuperscript{140} In addition, the New York State Medical Society's insurer for the past 25 years recently notified the Society that it would discontinue underwriting the

\textsuperscript{134} Id. at 13.
\textsuperscript{135} \textit{Stand Trial, supra} note 124, at 79.
\textsuperscript{136} Id. at 78.
\textsuperscript{137} For example, since the \textit{Garner} decision, insurance premiums paid by physicians insured under the Sacramento County Medical Society's group insurance policy have risen significantly. The most recent premium increase was a 15 percent rise effective in November, 1974. Telephone interview with Mr. William Dochterman, Executive Director of the Sacramento County Medical Society, Sept. 4, 1974. In addition, physicians in other Northern California counties who are insured through group insurance plans may experience similar premium increases. A general surgeon in the San Francisco Bay Area recently stated that he currently pays an annual premium of $4900 for $1 million of malpractice coverage. He noted, however, that his malpractice premiums in 1976 will be approximately $17,000 to $19,000 per year, if in fact he can obtain malpractice insurance. San Francisco Chronicle, Jan. 31, 1975, at 18, col. 3. In addition, in January, 1975, Argonaut Insurance Company, the largest malpractice insurer in Northern California, announced that it would cancel the group malpractice policies for physicians in eight Northern California counties. Argonaut's decision to discontinue providing malpractice coverage is particularly unfortunate since it is highly unlikely that any of the other three companies offering malpractice insurance in California will step in and furnish such coverage. San Francisco Chronicle, Feb. 1, 1975, at 1, col. 2.

\textsuperscript{138} \textit{See, e.g.}, \textit{Stand Trial, supra} note 124, at 77.
\textsuperscript{139} Id. at 77.
\textsuperscript{140} San Francisco Chronicle, Jan. 31, 1975, at 1, col. 8.
group’s malpractice insurance policy.\textsuperscript{141} Although the Society ultimately found a new insurer to underwrite its policy, its agreement with that insurer called for a 100 per cent increase on prevailing premiums.\textsuperscript{142} Moreover, in the last five years, physicians in Hawaii, Utah, Oregon, Nevada, Maryland, Florida and North Carolina either found themselves without malpractice coverage, or faced the possibility of being without such coverage.\textsuperscript{143}

The continued availability of adequate medical malpractice insurance for physicians is an absolute necessity.\textsuperscript{144} Malpractice insurance not only indemnifies physicians, thereby protecting their assets, but also provides the major source of compensation for most patients who are injured as a result of a physician’s negligence.\textsuperscript{145} Thus, the possibility that physicians might not be able to obtain medical malpractice insurance in the future should not be dismissed lightly.

**CONCLUSION**

The *Garner* decision may well have struck the death knell for the effective medical review committee. It is unfortunate that the *Garner* court did not recognize the flexibility provided by the medical review committee and its ability to work in conjunction with the malpractice insurer to determine the merits of a particular case. However, by transforming itself in either of two ways, the medical review committee may continue to exist despite the *Garner* decision.

First, the review committee could act as an advisory body to the insurance carrier, rather than as the ultimate authority on the question of whether to settle. This is the function presently being served by Sacramento County’s Review Committee.\textsuperscript{146} Although this method of operation may jeopardize the effectiveness of the medical review committee, it is clearly preferable to abolishing the committee altogether.

A second alternative is to transform the medical review committee into a panel composed of physicians and attorneys. It should be noted, however, that this type of panel has been the subject of considerable criticism. It probably has not stabilized the cost of malpractice insurance,\textsuperscript{147} nor has it served as a model

\begin{itemize}
  \item 141. Wall Street Journal, May 16, 1974, at 20, col. 4.
  \item 142. Id.
  \item 143. Commission on Medical Malpractice, supra note 12, at 39; San Francisco Chronicle, Jan. 31, 1975, at 18, col. 1.
  \item 144. Id. at 38.
  \item 145. Id.
  \item 146. Stand Trial, supra note 124, at 78.
  \item 147. Medical-Legal Screening Panels, supra note 40, at 717.
\end{itemize}
of cooperation between the medical and legal professions.\(^{148}\) Moreover, the panel's decision is generally not binding on the parties, and many persons have litigated their cases after an adverse panel decision.\(^{149}\) Finally, the insurance companies have been dissatisfied with the medical-legal committees for the alleged favor they have shown plaintiffs.\(^{150}\)

In summary, it appears that it may be difficult to find a satisfactory replacement for the all-physician review committee. In any event, it is clear that the \textit{Garner} decision has not provided any helpful solutions to the medical malpractice crisis.

\textit{Peter R. Boutin}

\begin{itemize}
\item \textit{148.} \textit{Id. at 721.}
\item \textit{149.} \textit{Id. at 716.}
\item \textit{150.} \textit{Id.}
\end{itemize}