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The Medical Review Panel in Louisiana Neurosurgery and Beyond

Jennifer Kosty, MD*
Bowen Jiang, MD‡
Devon C. LeFever, MD*
Jared R. Brougham, MD*
Frederick White, MD§
Katie Orrico, JD¶||
Bharat Guthikonda, MD*
on behalf of the Council of State Neurosurgical Societies (CSNS)

*Department of Neurosurgery, Louisiana State University Health Sciences Center Shreveport, Shreveport, Louisiana; ‡Department of Neurosurgery, Johns Hopkins University School of Medicine, Baltimore, Maryland; §Department of Cardiology, Willis-Knighton Health System, Shreveport, Louisiana; ¶Washington Office, American Association of Neurological Surgeons, Washington, District of Columbia; ||Congress of Neurological Surgeons, Schaumburg, Illinois

Correspondence:
Jennifer Kosty, MD,
Department of Neurosurgery,
LSU Health Sciences Center,
1501 Kings Hwy.,
Shreveport, LA 71130.
Email: jennifer.kosty@gmail.com

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For the past several decades, medical malpractice claims in the state of Louisiana have been screened by a pretrial medical review panel (MRP). Composed of 3 physicians and 1 attorney, these panels are a method of filtering nonmeritorious lawsuits while expediting creditable claims. Currently, 14 jurisdictions in the United States require medical liability/malpractice cases be heard by an MRP or screening panel prior to trial. In this article, we review the MRP process in Louisiana and compare it to those in other states. Data are presented for the past 10 yr of malpractice claims in Louisiana with an emphasis on the neurosurgery specialty. Finally, the benefits and challenges of pretrial screening panels are discussed.

KEY WORDS: Medical review panel, Pretrial screening panel, Medical malpractice, Tort reform

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Between 1990 and 2010, the National Practitioner Data Bank estimates malpractice and liability claims from adverse surgical events to be over $1.3 billion.[1] The bar for malpractice lawsuits may even be lowered following a 2017 Superior Court ruling in Pennsylvania that the known complications of a procedure are prejudicial to the plaintiff and inadmissible as evidence for the defense in a malpractice lawsuit.[2] Review of this case, which involved an inadvertent bowel injury during a cesarean section, is underway by the Supreme Court of Pennsylvania and a ruling is expected this year.[3] As malpractice claims increase in frequency, the United States civil justice system has taken measures to reduce the strain on the system. Many state legislatures have initiated reforms aimed at lowering litigation costs and keeping nonmeritorious claims to a minimum. These measures include damage caps, statutes of limitations, and pretrial medical review screening panels.[4]

In 1975, the Louisiana legislature established the Louisiana Patient's Compensation Fund (PCF) through the Louisiana Medical Malpractice Act 817.[5] This legislature's goal was to ensure an affordable and sustainable malpractice insurance environment for private health care providers (HCPs). The medical review panel (MRP) was created as a component of the PCF and is charged with screening liability claims prior to litigation in court.[6] The purpose of this review is to minimize the pursuit of frivolous claims while "provid[ing] a source of inquiry and relief for legitimate victims of medical malpractice."[5] Since its initiation, the MRP has remained an integral part of the medical malpractice and professional liability process in Louisiana.

Nationwide, 13 other states (Alaska, Hawaii, Idaho, Indiana, Maine, Massachusetts, Michigan, Montana, New Hampshire, New Mexico, Utah, and Wisconsin) require medical liability/malpractice cases be heard by a screening panel prior to initiation of litigation for all claims exceeding a minimal amount.[7] Delaware, Kansas, and Virginia have optional panels that can be called for by either party, and Nebraska has a panel that can be waived by the claimant. Connecticut, the District of Columbia, Nevada, New Jersey, South Carolina, and Washington require mediation or arbitration prior to litigation.[7] In this article, we evaluate the effectiveness and limitations of the pretrial malpractice screening process, particularly as it pertains to Louisiana and neurosurgery.

ABBREVIATIONS: HCP, health care provider; **MRP,** medical review panel; **PCF,** Patient's Compensation Fund

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The Louisiana MRP

The Louisiana MRP is comprised of 3 licensed HCPs, defined as "physicians who hold a license to practice in the state of Louisiana and who are engaged in the active practice of medicine in this state, whether in the teaching profession or otherwise," and 1 attorney or judge.[5] The review process allows for a thorough examination of both the defendant's and plaintiff's vantage point of the incident in question by an independent panel to determine the viability of the patient's complaint. Both parties theoretically benefit from the reduction of legal costs and lengthy trials in the absence of medical negligence, whereas situations in which true malpractice occurred may be settled or proceed to litigation with the use of the panel's findings as evidence.

Before a patient can file a medical malpractice/liability lawsuit against an HCP, the claim must be first submitted to the Louisiana Division of Administration, which then forward the claim to the PCF and an MRP.[8] The statute of limitations for filing a claim is 12 mo. As of the most recent PCF report from 2018, 1377 claims were filed for review in 2017, with an average of 1425 claims filed per year over the previous 5 yr.[9] It generally takes 2 yr for a claim to complete the MRP process and an additional 2 to 3 yr for a final conclusion of the claim. Although the 2018 report shows 108 more panels closed than filed, a backlog of cases has been generated over the years, and 4458 claims were still open as of 2018, with the oldest claim being filed in 1995. Prior to 2003, no fee was required to file a claim, and 2499 claims were filed in 2002. The institution of a fee of $100 per named defendant has been associated with a steady drop in the number of claims filed per year, with 2017 being the year with the lowest number of claims filed per year to date.

Over the years, amendments to the statute have created a PCF Oversight Board, which allowed HCPs to have more influence and responsibility in the organization. Private HCPs who enroll in PCF (over 20 000 in Louisiana) are responsible for the first $100 000 of a claim, while the PCF covers the remaining $400 000. State-employed HCPs are covered for up to the maximum $500 000 by a fund sponsored through the Office of Risk Management.

A claim must have the following information:

1. A statement that it is a request for the formation of an MRP.
2. The full name of the patient.
3. The full names of the claimants or plaintiffs.
4. The full names of the defendant HCPs.
5. The dates of the alleged malpractice.
6. A brief description of the alleged malpractice specific to each named defendant.
7. A brief description of the alleged injuries.

Once the claim is submitted, the PCF will notify the plaintiff within 15 d if the defendant(s) is qualified for the panel process and has coverage with the PCF. After the request for review has been filed, an attorney chairman is selected by consensus agreement from the 2 parties' litigation teams. If an agreement cannot be reached, the panel attorney will be chosen randomly from a list of 5 residing in the parish. This attorney acts primarily in an advisory capacity and oversees convening of the panel and certification of the results.[6] The attorney for the plaintiff and the defendant then each choose 1 HCP to sit on the panel, with the third panel member being chosen by the 2 initially selected HCPs. The HCP panelists must be within the same specialty as the defendant. If multiple specialties are involved in the alleged incident, the panel may consist of physicians from these varying specialties.

The panel has a 180-d period to render a decision. During this time, both parties can engage in the discovery process. Once the parties have gathered all the evidence for the MRP, a position paper is submitted to the attorney chairman along with medical records, imaging studies, witness testimonies, and medical expert depositions. This information is then delivered to each HCP on the MRP, and they are expected to thoroughly review the case. In surgical cases undergoing the MRP process in Louisiana, the physicians are expected to assess whether the preoperative surgical decision-making process, surgical procedure, and postoperative care were or were not within the standard of care. This algorithm is designed to allow differentiation between medical malpractice and a poor outcome that is not due to negligence. The attorney chairman then convenes the MRP, and the data are reviewed by the 3 panel HCPs and the chairman. Although the attorney chairman facilitates the deliberation process, he/she does not have voting power on the opinion.

By statute, the decision of the MRP is limited to only 1 of 3 possible outcomes: (1) the evidence demonstrates breach of the standard of care; (2) the evidence does not demonstrate breach of the standard of care; or (3) a question of fact exists bearing on the issue of liability which does not require expert opinion, and therefore, the MRP cannot render a decision.[10] Importantly, the scope of the inquiry is limited to the charges of the complaint, a policy that has been the subject of numerous attacks by the plaintiff bar in the experience of one of the senior authors (F.W.). If, for instance, the physician erred but the error was not included in the charges of the complaint, the physician may not be found at fault.

The costs of the MRP are paid by the prevailing party, which is often the defendant. These costs include a rate of $25 per diem, not to exceed $300, for each physician and $100 per diem, not to exceed $2000, for the attorney chairman. If the panel finds in favor of the claimant, that party is responsible for the fees unless they are unable to pay and an in forma pauperis ruling is issued by a district court.[8] In this case, the costs of the MRP are paid by the HCP defendant with the caveat that if the claimant receives a favorable judgment or a settlement, the payment of the MRP will be offset.

Statistically, the MRP finds in favor of the plaintiff in only about 3 to 5% of the cases.[10] Because the MRP finding is admissible in court and carries substantial weight, the majority of filed malpractice suits in Louisiana are either dropped or settled. However, if the MRP does find a breach in the standard of care,

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then it is also the responsibility of the MRP to determine if this breach of care resulted in damage to the patient. Following a decision, the plaintiff has 90 d to initiate a lawsuit in district court or the case will be dismissed. In the scenario in which the MRP cannot render a decision, it is again the responsibility of the plaintiff to file litigation within 90 d in state district court.

Once a lawsuit is filed, the opinion of the MRP is admissible in court. The party receiving the favorable ruling from the MRP will generally call the panel members as witnesses at the trial. It is important to note that the plaintiff has the right to pursue a medical malpractice claim in a court of competent jurisdiction, regardless of the outcome/opinion of the MRP. However, if a unanimous opinion from the MRP is rendered in favor of the defendant, the claimant who proceeds to file a suit will be required to post a cash or surety bond in the amount of all costs of the MRP.[8] If the claimant does not prevail in the lawsuit, this bond is forfeited to the defendant for reimbursement of the costs of the MRP.

The MRP and PCF are completely self-funded by physician participants, filing fees, and investment income. In 2017, operating expenditures as of August 31 totaled $837 957. By extrapolation, the yearly charges for operation would be expected to be $1 245 700. Individual HCPs or incorporated HCP groups joining the fund must establish and maintain a deposit of $125 000 to cover malpractice claims in addition to recurring surcharges based upon provider type and years enrolled in the fund. In 2018, this was estimated as $20 314 per year for general surgery. Until 2013, liabilities for the fund exceeded assets. Over time, however, increased resources from elevating physician surcharges and implementing a filing fee for plaintiffs, combined with a decrease in number of claims filed, has led to an excess of assets. In the 2017 fiscal year, the total assets of the PCF amounted to $1 078 517 338, and estimated liabilities were $769 800 000, leaving a surplus of $308 717 338.[9]

MRP in Louisiana Neurosurgery

MRPs have been of enormous benefit to the physicians of Louisiana by providing a third-party expert review of cases. Despite Louisiana having the highest number of malpractice claims per 100,000 people in 2015, it ranked 40th in the nation for estimated average payout per total claims filed that year (Table 1).[11] The reason for Louisiana's high claims frequency is unclear, although the relatively low barrier to entry of a $100 claim filing fee may be one cause.[12] This has been especially true for Louisiana neurosurgeons. Data obtained via public records request from the Louisiana PCF show that over the past decade there have been no malpractice trial judgments against a neurosurgeon.[13] Data showing the results from all filed MRPs in the state of Louisiana over the past 10 years are shown in Table 2, and results for neurosurgery claims can be found in Table 3.

On average, there were 67 neurosurgical cases submitted before the panel annually. Of those, a mean of 1 was dismissed because of paucity of facts, 29 were found in favor of the physician, 4 were found against the physician, and 23 were dismissed before a decision was rendered by the MRP. A settlement was made in 15.2% (102/670) of MRPs despite only 6.1% (41/670) of cases finding that the neurosurgeon was not within the standard of care.[13] This is likely due to the fact that many cases are settled prior to MRP decision. The total payout for the past 10 yr for all neurosurgical cases was $31 928 937, with an average of $313 028.79 per settlement (range: $10 000-$1 250 000).[13] This is lower than the average $344 811.00 settlement per case for neurosurgeons nationally.[14] In addition to these financial benefits, MRP rulings in Louisiana have lowered the amount of time physicians are required to be in court and saved government resources by decreasing the frequency of trials.

Other Tort Reforms in Louisiana: Damage Liability Cap and Statue of Limitations

In addition to the MRP, the Louisiana Medical Malpractice Act also stipulates a statutory cap on the total damage liability to $500 000, plus judicial interest beginning from the date of the claim filing, and ongoing medical expenses related to the claim. In 2017, there were 284 settlements through the PCF for a total claim payment of $87 526 089, an average of $308 190 per case.[15] In 2012, the constitutionality of the $500 000 cap was challenged in *Oliver v. Magnolia Clinic*, in which the family of a female pediatric patient with neuroblastoma was awarded $10 million by a jury but was limited by the statutory cap. The case was brought to the attention of the Louisiana Supreme Court who reaffirmed the state cap and the constitutional grounding of the previous statures.[16]

The effect of damage caps on the frequency of claims and malpractice insurance premiums is a source of some controversy, though there is considerable evidence that caps decrease both. In a thorough review on the subject, Nelson et al[17] report that most studies have demonstrated a reduction or slowed increase in malpractice insurance premiums in states with a damages cap. Several groups have found a decrease in paid claim rates associated with the implementation of total and noneconomic damage caps,[18-20] although the effect is more pronounced with caps <$250 000.[20] Currently, 30 states have damage caps in place, 2 with caps on both pain and suffering as well as an absolute cap, and 4, including Louisiana, with only a total cap in place (**Table**, **Supplemental Digital Content 1**).[21] Eight states have found them to be unconstitutional.

In addition to the damage liability cap, Louisiana has a relatively stringent statute of limitations: one year from the act or date of discovery, but no more than 3 yr from the date of injury. Most other states allow at least 2 yr from the act or discovery for a claim to be filed; only Louisiana, Tennessee, and Ohio limit the timeframe to 1 yr.[22] The effect of a short statute of limitations is a decrease in the claim frequency, and possibly also malpractice premiums.[23,24]

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TABLE 1. 2015 Malpractice Claims and Payouts by State

Mandatory screening panel	State	Malpractice claims per 100 000 residents	Total payouts in 2015 (million dollars)[32]	Estimated payout per claims filed[32a]
Y	Massachusetts	15.3	205	194 184
N	New York	19.3	711.7	189 106
N	Connecticut	16.4	85.8	145 325
N	Illinois	14.3	258.2	142 173
Y	New Mexico	17.9	50.8	135 142
N	Pennsylvania	22.7	374	128 717
N	West Virginia	29.6	50.2	94 219
N	Georgia	11.3	111.5	93 974
N	New Jersey	30.4	256.3	93 677
Y	Hawaii	4.9	6.2	90 379
N	Rhode Island	20.6	17.9	86 893
N	Maryland	21.1	108.6	85 782
Y	New Hampshire	13.4	13.9	74 094
N	Florida	16.2	248.9	72 473
Y	Montana	14.8	8.2	55 405
N	South Dakota	12.1	5.7	52 342
N	North Carolina	10	51.4	49 423
N	Minnesota	17.7	48	48 426
N	Nevada	18.7	25.2	44 920
N	South Carolina	18.8	42	44 681
Y	Maine	30.2	16.8	42 792
Y	Kentucky	21.5	42.8	42 355
Y	Kansas	19.7	23.3	40 784
N	Arizona	24.4	71.5	40 699
N	California	16.9	263.8	39 518
Y	Indiana	20.7	53.3	38 431
N	Missouri	28.8	66.9	38 081
Y	Wyoming	34	7.5	38 032
N	Vermont	23.2	5.3	36 846
N	Iowa	15.2	17.9	36 801
Y	Idaho	13.6	8.5	36 765
Y	Alaska	21.8	5.7	35 818
N	Oregon	28.6	42.9	35 714
Y	Utah	15	16.4	34 167
N	Mississippi	16.9	17.1	33 728
Y	Delaware	35.2	11.6	32 955
N	Colorado	24.4	43.9	31 565
N	Michigan	23.3	71.6	31 040
Y	Virginia	23	56.7	29 003
Y	Louisiana	44.1	59	28 465
Y	Nebraska	25.6	13.7	28 166
N	Ohio	27.5	88.7	27 568
N	Oklahoma	36.3	32.5	22 957
N	Washington	29	49.1	22 575
N	Tennessee	33	45.9	20 455
N	Arkansas	32.2	19.6	20 290
N	North Dakota	21.5	2.8	17 136
N	Wisconsin	16.9	14.1	14 385
N	Alabama	29.5	20.2	13 974
N	Texas	25.4	75.9	10 412

[a]Determined by multiplying the claims per 100 000 people by the total population to estimate total claims per the period studied, then dividing total payouts by estimated total claims.

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TABLE 2. **MRP Opinions for All Claims Filed With the Louisiana Patient Compensation Fund 2008-2017**

Year filed	Fact	Lost	None	Pending	Won	*Total opinions*
2008	34	138	601	5	813	1591
2009	44	143	567	1	775	1530
2010	51	169	582	5	796	1603
2011	45	162	683	11	794	1695
2012	44	142	441	18	737	1382
2013	43	130	487	38	710	1408
2014	40	139	478	116	624	1397
2015	37	99	438	335	568	1477
2016	7	50	366	713	246	1382
2017	0	4	237	1119	17	1377
Total opinions	345	1176	4880	2361	6080	14 842

Won: MRP found in favor of the physician and that the standard of care was met; *Lost:* MRP found in favor of the plaintiff and the standard of care was not met; *Fact:* There is a material issue of fact, not requiring expert opinion; *None:* No decision was rendered.

TABLE 3. **MRP Opinions for Neurosurgery Claims Filed With the Louisiana Patient Compensation Fund 2008-2017**

Year filed	Fact	Lost	None	Pending	Won	Total opinions
2008		3	13		29	45
2009	3	5	17		32	57
2010	2	12	78		93	185
2011		7	73		65	145
2012	1	7	12	1	22	43
2013	1	1	12	3	19	36
2014	2	3	6	10	13	34
2015		2	9	8	14	33
2016		1	10	32	6	49
2017			2	40	1	43
Total opinions	9	41	232	94	294	670

Won: MRP found in favor of the physician and that the standard of care was met; *Lost:* MRP found in favor of the plaintiff and the standard of care was not met; *Fact:* There is a material issue of fact, not requiring expert opinion; *None:* No decision was rendered.

Medical Screening Panels in Other States

Outside of Louisiana, the MRP is known by various names in different jurisdictions. For instance, the MRP is called an "expert advisory panel" in Alaska, "medical inquiry and conciliation panel" in Hawaii, and "malpractice screening panel" in Maine. Despite the nomenclature, all the panels are prelitigation screening measures and typically are comprised of at least one medical and one legal professional. In some panels, a layperson (Idaho) or retired judge (Maine) is included. The size of the panels can vary from 2 members (Hawaii) to as many as 6 members (Montana and New Mexico). Although 30 jurisdictions (including District of Columbia, Guam, and Puerto Rico) have provisions for alternative dispute resolution, 17 jurisdictions currently have a prelitigation MRP in place (**Table**, **Supplemental Digital Content 2**). The fundamental premise of these screening panels is to determine if a medical malpractice claim is warranted before entering the high-cost litigation system.[4]

Generally, MRP proceedings are informal and mandatory in the pretrial setting. An exception is Indiana, where a patient may commence an action for malpractice without an MRP if the plaintiff is seeking an amount no greater than $15 000.[7] Although all MRPs are asked to render an opinion on whether a claim is a violation of the standard of care (assessment of liability), some panels can assess damages. Namely, Delaware, Hawaii, Idaho, and Montana have some authority on settlement negotiations.

The constitutionality of MRP and other elements of tort reform (namely statutory caps) have persisted in the medical legal debate. A consistent contention is that mandatory pretrial MRPs violate the Equal Protection Clause of the United States Constitution and have discriminatory effects on plaintiffs. Historically, courts have applied the rational standard basis and typically ruled that MRPs serve legitimate legislative purpose to reduce malpractice insurance costs and thereby make available quality health care for all citizens.[25] However, the Kentucky Supreme Court recently ruled that its MRP was unconstitutional because it delayed access to the courts, a right guaranteed by the Kentucky Constitution.[26]

Another challenge to the MRP's constitutionality is the due process argument. That is, by restricting the cases that proceed to litigation, the MRP is argued to infringe on plaintiffs' right of access to the court system. Proponents for the MRP argue that even if it does rule in favor of the defendant, the plaintiff still has a right to proceed to litigation. Within the high courts, the Wisconsin Supreme Court rejected the due process argument, stating that "due process is satisfied if the statutory procedures provide an opportunity to be heard in court at a meaningful time and in a meaningful manner."[27] Conversely, the Missouri Supreme Court argues that MRPs impose arbitrary delays to litigation access and deemed them unconstitutional.[28] Another contentious provision in the MRP debate is the admissibility of the panel findings at trial. Currently, the opinion/decisions of 10 state panels are admissible in court, whereas 7 are not (Table 4). Some states require that the panel decision be unanimous as a prerequisite to admissibility.

Limitations of Medical Screening Panels

Although the goals of an MRP include reduction in the legal burden of malpractice claims and by extension, malpractice insurance rates, not all states have found this to be the case. For instance, in Arizona, the implementation of an MRP actually led to an increase in the number of disputes seeking formal adjudication due to a lower financial barrier to entry, an increase in the cost of the malpractice litigation process, and a lengthening of the time spent in legal disputes.[12] Others have similarly found that MRPs can increase the amount of time needed to process a claim and result in a backlog of claims with only half of all

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TABLE 4. Medical Liability/Malpractice Screening Panel Statutes in United States Jurisdictions

State	Statute	Provisions[33]	Admissibility	Size	Damage cap[34]
Alaska	09.55.535, 09.55.536	**Pretrial.** If no agreement for arbitration, court appoints **expert advisory panel** within 20 d of filing. The panel answers the following: (1) Why did the claimant seek medical care? (2) Was a correct diagnosis made? If not, what was incorrect about the diagnosis? (3) Was the treatment or lack of treatment appropriate? If not, what was inappropriate about the treatment or lack of treatment? (4) Was the claimant injured during evaluation or treatment or by failure to diagnose or treat? (5) If the answer to question 4 is "yes," what is the nature and extent of the medical injury? (6) What specifically caused the medical injury? (7) Was the medical injury caused by unskillful care? Explain. (8) If a medical injury had not occurred, what would have been the likely outcome of the medical case?	Admissible	3	$400 000 noneconomic damages including wrongful death or disability considered more than 70% disabling, otherwise cap is $250 000.
Delaware	Title 18, 6811, 6812	**Pretrial. Medical negligence review panel** composed of 2 health care providers, 1 attorney, 2 laypersons. The panel renders one of the following. (1) The evidence supports the conclusion that the defendant failed to comply with standard of care. (2) The evidence does not support the conclusion that the defendant failed to meet standard of care. (3) There is material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury. (4) The conduct complained of was or was not a factor in the resultant damages and if so, whether the plaintiff suffered any disability and the extent/duration of disability and if any permanent impairment.	Admissible	5	None
Hawaii	RV 671-11, 12, 13, 16	**Pretrial. Medical inquiry and conciliation panel** with attorney and physician. Proceedings are informal and advisory. The panel may encourage settlement or inquiry disposition voluntarily. Aims at conciliation of differences.	Inadmissible	2	$375 000 with limited exceptions for cases involving multiple defendants.
Idaho	6-1001, 1002, 1004, 2301	**Pretrial. Hearing panel in the nature of a special civil grand jury and procedure for prelitigation consideration.** Panel determines if matter is frivolous, meritorious, or other. Compulsory as a condition precedent to litigation. Informal process.	Inadmissible	3	$250 000, adjusted annually for inflation, $357 210.62 in 2018.
Indiana	34-8-4,6. 18-10-1, 22, 23	**Pretrial.** A patient may commence an action for malpractice without a **medical review panel** if the patient seeks damages from the health care provider in an amount not greater than $15 000. The panel aims to decide: (1) The evidence supports the conclusion that the defendant or defendants failed to comply with the appropriate standard of care as charged in the complaint. (2) The evidence does not support the conclusion that the defendant or defendants failed to meet the applicable standard of care as charged in the complaint. (3) There is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury. (4) The conduct complained of was or was not a factor of the resultant damages. If so, whether the plaintiff suffered: (A) Any disability and the extent and duration of the disability; and (B) Any permanent impairment and the percentage of the impairment.	Admissible	4	$1 250 000 for total damages; providers are liable for $250 000.

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TABLE 4. ***Continued***

State	Statute	Provisions[33]	Admissibility	Size	Damage cap[34]
Kansas	60-3413, 65–4901, 4903, 4904	**Pretrial.** A settlement conference needs to be held 30 d before trial. Upon request, a **medical malpractice screening panel** will determine if a departure from the standard of practice has been made for claims of personal injury damage or death on account of alleged medical malpractice not yet formalized by petition filing.	Admissible	4	$2 50 000 cap for causes of action accruing from July 1, 1988 to July 1, 2014; $300 000 cap for causes of action accruing from July 1, 2014 to July 1, 2018; $325 000 cap for causes of action accruing from July 1, 2018 to July 1, 2022; $350 000 cap for causes of action accruing on or after July 1, 2022.
Louisiana	RS 40:1299.47	As detailed in current manuscript.	Admissible	4	$500 000 total damages, plus the cost of future medical expenses.
Maine	Title 24, 2851, 2853, 2855, 2857	**Pretrial. Malpractice screening panels** are mandatory unless both parties agree to bypass the panel. Answers the following questions: (1) Whether the acts or omissions complained of constitute a deviation from the applicable standard of care by the health care practitioner or health care provider charged with that care; (2) Whether the acts or omissions complained of proximately caused the injury complained of; and (C) If negligence on the part of the health care practitioner. (3) Health care provider is found, whether any negligence on the part of the patient was equal to or greater than the negligence on the part of the practitioner or provider.	Inadmissible	3-4	$500 000 cap on wrongful death only.
Massa-chusetts	Mass. Gen. Laws Ann. Ch. 231, 60B	**Pretrial.** Every action for malpractice, error, or mistake against a health care provider shall be heard by a **tribunal** consisting of a single justice of the superior court, a licensed physician, and a licensed attorney. The tribunal shall determine if the evidence presented if properly substantiated is sufficient to raise a legitimate question of liability appropriate for judicial inquiry or whether the plaintiff's case is merely an unfortunate medical result.	Admissible	3	$500 000 unless there is a "substantial or permanent loss or impairment of a bodily function or substantial disfigurement or other special circumstances that would warrant a finding that imposition of such limitation would deprive plaintiff or just compensation for injuries."
Montana	27-6-101, 202, 606, 704	**Pretrial.** A **medical legal panel** reviews a case prior to filling in any district court. The panel decides whether there is: (1) substantial evidence that the acts complained of occurred and that they constitute malpractice; and (2) a reasonable medical probability that the patient was injured thereby.	Inadmissible	6	$250 000
Nebraska	44-2840, 2843, 2844	**Pretrial. Medical review panels** can be waived by the claimant if desired. The expert opinion renders: (1) the evidence supports the conclusion that the defendant failed to comply with the appropriate standard of care as charged in the complaint in specified particulars; (2) the evidence supports the conclusion that the defendant involved met the applicable standard of care required under the circumstances; or (3) there is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury in specified particulars.	Admissible	4	$1 250 000 for malpractice occurring between 1993 and 2003, $1 750 000 for malpractice occurring between 2004 and 2014, $2 250 000 for malpractice occurring after 2014.

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TABLE 4. ***Continued***

State	Statute	Provisions[33]	Admissibility	Size	Damage cap[34]
New Hampshire	519-B:1, 4, 6, 8	The purposes of the **pretrial medical malpractice screening panels** are: (1) to identify claims of professional negligence which merit compensation and to encourage early resolution of those claims prior to commencement of a lawsuit; and (2) to identify claims of professional negligence and to encourage early withdrawal or dismissal of nonmeritorious claims. The panel answers the following: (1) whether the acts or omissions complained of constitute a deviation from the applicable standard of care by the medical care provider charged with that care; (2) whether the acts or omissions complained of proximately caused the injury complained of; and (3) if fault on the part of the medical care provider is found, whether any fault on the part of the patient was equal to or greater than the fault on the part of the provider.	Inadmissible	3	Cap found unconstitutional (court struck down a bill to impose a $875 000 cap on all personal injury noneconomic damages).
New Mexico	41-5-14, 41-5-20	**Pretrial. New Mexico medical review commission** provides panels to decide only 2 questions: (1) whether there is substantial evidence that the acts complained of occurred and that they constitute malpractice; and (2) whether there is a reasonable medical probability that the patient was injured thereby.	Inadmissible	6	$600 000 cap on all damages except for past/future medical bills $200 000 maximum provider liability.
Utah	78B-3-416, 418, 419, 420	**Pretrial. Prelitigation panel review.** Informal and nonbinding. Aims to answer if: (1) each claim against each health care provider has merit or has no merit; and (2) if a claim is meritorious, whether the conduct complained of resulted in harm to the claimant.	Inadmissible	3-4	$450 000 constitutional provision prohibiting caps on wrongful death claims.
Virginia	8.01-581.01, 07, 08, 012	**Pretrial.** Any party may request a review by a **medical malpractice review panel.** The panel renders one or more of the following opinions: (1) the evidence does not support a conclusion that the health care provider failed to comply with the appropriate standard of care; (2) the evidence supports a conclusion that the health care provider failed to comply with the appropriate standard of care and that such failure is a proximate cause in the alleged damages; (3) the evidence supports a conclusion that the health care provider failed to comply with the appropriate standard of care and that such failure is not a proximate cause in the alleged damages; or (4) the evidence indicates that there is a material issue of fact, not requiring an expert opinion, bearing on liability for consideration by a court or jury.	Admissible	5	$2 300 000 total damages until July 2018, set to rise $50 000 each year until it tops out at $3 000 000 in 2031.
Wyoming	9-2-1513, 9-2-1521, 1522, 1523	**Pretrial.** No complaint alleging malpractice shall be filed in any court against a health care provider before a claim is made to the **medical review panel** and its decision is rendered. The panel shall determine whether there is: (1) substantial evidence that the acts complained of occurred and that they constitute malpractice; and (2) a reasonable probability that the patient was injured because of the acts complained of.	Admissible	5	

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cases receiving an opinion each year.[29] During the arbitration process, both parties accrue legal fees, which may be substantial in states where the panel ruling is admissible in court and extensive discoveries are undertaken.[29] Several have also failed to find a relationship between mandatory MRPs and lower malpractice premiums.[30] In our own analysis of the average payout per total filed malpractice claims in 2015 using data published by Becker's Hospital Review, we found no significant difference in the average payout per claim filed between states with and without a pretrial screening panel ($57 500 ± $44 800 vs $56 500 ± $43 600, Student t test $P = .94$).[11] This analysis, which is calculated by dividing the total payouts estimated for the population of the state by the total number of claims filed in 2015, is a rough surrogate for the financial successfulness of a filed claim. It is not the average payout per successful claim, which was $353 000 for the period from 2009 to 2014,[31] and also includes claims that were dropped or settled. Finally, MRPs comprised of physicians, such as in Louisiana, may tend to bias decisions toward the defendant. At the same time, discriminating between medical malpractice and a bad outcome is a great challenge that is likely most appropriately accomplished by physicians of the same specialty as the defendant.

CONCLUSION

MRPs and other forms of pretrial screening processes can be an effective mechanism to reduce the number of non-negligent malpractice claims that proceed to full litigation. A damage liability cap and relatively short statute of limitations have also discouraged excessive and frivolous claims. In Louisiana, these factors have likely contributed to the occurrence of zero malpractice trials with a judgment against a neurosurgeon in the past decade. Although MRPs can lengthen the processing of a malpractice claim, adequate infrastructure and experience with this procedure can be both time and cost saving for many litigants.

Disclosures

The authors have no personal, financial, or institutional interest in any of the drugs, materials, or devices described in this article.

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***Supplemental digital content** is available for this article at www.neurosurgeryonline.com.*

Supplemental Digital Content 1. Table. State-by-state breakdown of medical malpractice damage caps (alphabetical order).

Supplemental Digital Content 2. Table. Medical liability/malpractice screening panel statutes in the United States jurisdictions.

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COMMENT

This paper represents a useful non-clinical addition to our literature. The authors describe their experience with Louisiana's Medical Review Panel (MRP) with special emphasis on neurosurgery. Costs associated with medical malpractice is a complex subject, but clearly adds considerably to the overall cost of healthcare. Several mechanisms have been tried to reduce non-meritorious claims including pretrial review panels such as the one described in this report. The Louisiana MRP has a long history, dating to 1975, and has proven to be economically sustainable, self-funding mechanism. As the authors point out, many states that have established MRPs for this purpose have seen the laws struck down by their judiciary for various reasons including denial of equal protection under the 14th amendment. The authors note that there has been no judgment at trial against a neurosurgeon in the state of Louisiana in the past 10 years and that the average payout for a neurosurgical settlement was lower than the national average. This is likely the result of a high disincentive to proceed to litigation when the MRP finds for the defendant and, conversely, a high degree of motivation for settlement when the finding favors the plaintiff. Further, Louisiana also has a cap on damages of $500 000 and a relatively short statute of limitations of 12 months which likely contribute to these results. The authors are to be congratulated for compiling their experience in Louisiana in comparison to other states which underscores the ongoing need for a national discourse and policy regarding Tort Reform in general.

Michael J. Rutigliano
Pittsburgh, Pennsylvania

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