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INTRODUCTION

During the past two decades, the United States has witnessed several malpractice "crises," characterized by a lack of availability of medical malpractice insurance. In large part, these crises have been triggered by marked increases in medical malpractice claims frequency and/or claims severity—that is increases in the number of claims filed and/or the size of settlements or judgments.

Recently, the insurance industry reported that during the period between 1985 and 1990, there was a moderation in the frequency of claims being filed, although the size of claims continued to increase.[1] This national experience continued into the early 1990s, with the number of claims per 100 physicians falling from 14.3 in 1991 to 14.1 in 1992.[2] Nevertheless, the median verdict for medical malpractice claims during the period between 1987 and 1991 rose from approximately $350,000 to approximately $465,000, a trend that is expected to continue.[3] Moreover, reports from various sources indicate that the down-

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1. Ruth Gastel, *Medical Malpractice, in* INSURANCE INFORMATION INSTITUTE, INSURANCE ISSUES UPDATE (Oct. 1993).

2. *Id.*

3. Christine Woolsey, *Jury Awards Rise*, BUS. INS., Apr. 12, 1993, at 2, 17.

ward trend in claims frequency may now be coming to an end.[4]

A renewed growth in claims frequency may be traced, in part, to a variety of recent judicial decisions that appear to expand the scope of physician accountability within the framework of the physician-patient relationship. Based upon both substantive and procedural considerations, these decisions have legitimized, or reinforced the legitimacy of, a broad array of malpractice causes of action. The first section of this article will examine selected decisions that have expanded physicians' duties, while the second section will look at examples of legislative efforts to curb the growth of medical malpractice claims.

I. Common Law Developments

In the March, 1993 case of *Faya v. Almaraz*,[5] Maryland's highest court addressed the question of whether or not a surgeon who is infected with the AIDS virus is legally obligated to inform his or her surgery patients of this fact prior to performing surgery. Rudolph Almaraz, a surgeon who specialized in treating breast cancer, knew that he was HIV positive. Despite this fact, he performed a partial mastectomy and axillary dissection on Sonja Faya in 1988, followed by removal of an axillary hematoma in early 1989. In October of 1989, Dr. Almaraz was diagnosed with AIDS. A month later, he surgically removed a benign lump from the breast of Perry Rossi.

Due to his illness, Dr. Almaraz gave up his medical practice in March of 1990. He died approximately eight months later, at which time Ms. Faya and Ms. Rossi learned of their surgeon's illness from local newspapers. Both underwent blood testing for HIV but neither showed evidence of seroconversion. Nevertheless, both patients sued the estate of Dr. Almaraz and Johns Hopkins Hospital for compensatory and punitive damages. Although neither plaintiff challenged the therapeutic outcome of their surgeries, both alleged that Dr. Almaraz acted wrongfully by failing to inform them of his illness prior to operating on them. As a result, the plaintiffs argued that Dr. Almaraz placed them at risk of exposure to AIDS—a risk that might otherwise have been avoided if they had been properly informed and had refused to consent to the invasive surgery. The plaintiffs claimed that they suffered from severe emotional distress and

4. Gastel, *supra* note 1; Brian McCormick, *Liability Premiums Going Up; Unclear How Many, How High,* Am. Med. News, Dec. 6, 1993, at 1.

5. 620 A.2d 327 (Md. 1993).

anxiety as a result of the risk of exposure to HIV as well as the need for continued testing and surveillance for the disease.

The defendants moved for dismissal on the grounds that the plaintiffs failed to state a cause of action. The estate of Dr. Almaraz claimed that disclosure of HIV status is not an element of the informed consent information exchange between physician and patient. The hospital claimed that it had no duty to investigate and determine the health status of Dr. Almaraz nor was it obligated to make any disclosures to the plaintiffs under the doctrine of informed consent. Both defendants further argued that the plaintiffs' complaints were not legally cognizable because neither plaintiff had contracted the AIDS virus.

The trial court agreed and dismissed the claims, noting that there were "no reported cases of transmission of AIDS from a surgeon to a patient."[6] Moreover, the court stated that such transmission "is only a theoretical possibility when proper barrier techniques are employed . . . ."[7] In the case at bar, the plaintiffs had not alleged that Dr. Almaraz negligently failed to use proper barrier techniques. The trial judge also refused to accept the theory that recovery in such a case could be based on a fear of contracting AIDS when, at the time of litigation, the plaintiffs were not HIV positive.

The Maryland Court of Appeals issued a special writ to address what it considered to be an important and timely issue. Noting that the concept of legal duty emanates from a responsibility to exercise due care, the court held that regardless of the fact that there is an extremely low risk of HIV transmission in the types of surgeries performed on the plaintiffs, the risk may nevertheless be viewed as unreasonable. In reversing the trial court's dismissal of the plaintiffs' complaints, the Maryland high court stated that it was unable to conclude "as a matter of law that no duty was imposed upon Dr. Almaraz to warn the [plaintiffs] of his infected condition or [to] refrain from operating upon them."[8]

The court further ruled that the plaintiffs' fears of acquiring HIV infection, accompanied by headaches, inability to sleep, and physical and mental anguish due to the need for repeated HIV testing, could constitute legally compensable injuries. Recovery would be permitted for injuries suffered between the

6. *Id.* at 330.
7. *Id.*
8. *Id.* at 333-34.

time the plaintiffs learned of the surgeon's illness and the time of a relatively certain negative test result—an approximate six-month period.[9]

While this case of first impression in Maryland appears to be far reaching in articulating the scope of physician accountability for disclosure under the doctrine of informed consent, it does not stand alone. Similar cases have expanded physician disclosure obligations to include information about HIV infection[10] and chronic alcohol abuse.[11] Courts have also expanded physician accountability in situations where plaintiffs suffer negligently inflicted emotional distress.

In a 1993 Virginia case, *Howard v. Alexandria Hospital*,[12] the plaintiff filed a malpractice action claiming that during carpal tunnel surgery, certain instruments were used that had not been sterilized adequately. The plaintiff claimed that as a direct result, she sustained pain and suffering, mental anguish, inconvenience, discomfort, and "increased anxiety in the extreme," particularly with respect to the possibility of getting AIDS. At trial, the evidence established that while the plaintiff was in the recovery room, the surgeon advised her of the possibility that the instruments he used were possibly not sterile. It appeared that a nurse in charge of the autoclave, a machine used to sterilize instruments, failed to properly monitor the equipment. Upon being informed of this fact, the plaintiff experienced fear of several diseases including AIDS, hepatitis B, staphylococcal infection, and tetanus.

The surgeon asked an infectious disease specialist to attend the plaintiff while she was in the hospital. During the three-day period following the surgery, the plaintiff experienced severe headaches, nausea, and vomiting. She received pain medication and intravenous antibiotics. Following her release from the hos-

9. *Id.* at 336-37.

10. *See* K.A.C. v. Benson, 1993 Minn. App. LEXIS 1201 (Dec. 14, 1993) (relying on *Faya*), *review granted*, 1994 Minn. LEXIS 155 (Feb. 24, 1994); Estate of Behringer v. Medical Ctr. at Princeton, 592 A.2d 1251, 1279-83 (N.J. Super. Ct. Law Div. 1991) (duty to disclose HIV infection prior to performing invasive ontology, or ear, nose, and throat, surgery). For a more detailed discussion of this topic, see Theodore LeBlang, *Obligations of HIV-Infected Health Professionals to Inform Patients of Their Serological Status: Evolving Theories of Liability,* 27 J. MARSHALL L. REV. 317 (1994).

11. Hidding v. Williams, 578 S.2d 1192 (La. Ct. App. 1991) (decompressive laminectomy was followed by loss of bowel and bladder control; informed consent should have included information about surgeon's chronic alcohol abuse prior to and at time of surgery).

12. 429 S.E.2d 22 (Va. 1993).

pital, the plaintiff was required to take medications that apparently caused nausea and vomiting as well as a raw mouth, nose, and sinus cavity. She was also informed that HIV testing would be necessary in six months.

At the conclusion of the plaintiff's trial, the defendants moved to strike the plaintiff's evidence on the grounds that her claim essentially stated a cause of action for negligent infliction of emotional distress, which was not recognized as a compensable injury. The court granted the motion, concluding the trial.

On appeal, the Virginia Supreme Court ruled that the hospital's use of improperly sterilized medical equipment caused the plaintiff to suffer physical pain and discomfort as well as mental anguish and emotional distress—resulting from fear about her own physical condition and about possible contamination of her family and friends. In light of these facts, the Virginia Supreme Court held that the trial court erred when it struck the plaintiff's evidence and ordered a summary judgment.[13] In reaching this decision, the court grappled with the extent to which it would recognize and support a cause of action for infliction of emotional distress—a claim which, in Virginia, ordinarily requires contemporaneous physical injury to the plaintiff. The court concluded that headaches, nausea, vomiting, unusual sweating, and a "raw" mouth, nose, and sinus cavity constituted sufficient physical injury to sustain the plaintiff's claim.

A New Jersey court was willing to go even further in this regard. In the 1993 case of *Carey v. Lovett*,[14] the New Jersey Supreme Court held that parents could recover for emotional distress caused by malpractice resulting in the premature birth and death of their baby—without being required to prove physical injury to themselves. The plaintiff, JoAnn Carey, suffered from diabetes. Her first child was delivered one month premature and, although suffering from toxemia, was otherwise healthy. A second pregnancy ended in miscarriage. In October of 1983, while in the twenty-sixth week of her third pregnancy, the plaintiff awoke one morning with elevated blood sugar levels, which she was unable to lower throughout the day. Following numerous telephone calls to the office of her internist, who had managed her other pregnancies, she was told to report to the hospital the next morning. In a subsequent telephone call from the hospital, she was told to report in the afternoon rather

13. *Id.* at 24.
14. 622 A.2d 1279 (N.J. 1993).

than the morning. She was admitted at 1:00 p.m. with a diagnosis of "uncontrolled diabetes, six months pregnant."[15]

Shortly after her admission to the hospital, the plaintiff was examined by a physician who was covering for her internist. He concluded that she was suffering from ketoacidosis, a dangerous condition resulting from excess acidity of the blood. Because the condition often causes intrauterine death, the physician listened for fetal heart sounds but detected none. The hospital notified the plaintiff's obstetrician of the examination results. Shortly thereafter, the plaintiff experienced strong contractions. Two nurses were unable to detect fetal heart sounds. A third nurse was contacted who was also unable to hear fetal heart sounds. The nurses telephoned the plaintiff's husband and her obstetrician. The obstetrician advised the nurses to allow the plaintiff to deliver what he expected would be a stillborn child.

The plaintiff's husband went directly to the hospital, where a nurse informed both him and his wife that there were no audible fetal heart tones and that the fetus was dead. The plaintiff insisted that she could feel the fetus moving inside her and the nurse again tested for fetal heart tones, finding none. She did not use an ultrasound, a more accurate way of detecting fetal viability.

Approximately eight hours after the plaintiff was admitted to the hospital, she delivered a baby in a breech position. The plaintiff's obstetrician was not present and neither of the two nurses assisted in the actual delivery; the infant dropped unsupported onto the labor bed. One nurse cut the umbilical cord and a second nurse took the baby into another room, closed the door, and placed the surprisingly healthy-looking baby on a weighing scale, at which time the baby gasped for air. The nurse detected a fetal heartbeat and the infant was rushed to the neonatal nursery. The child was severely brain damaged. Approximately ten days later, the child was removed from life support machines while in a persistent vegetative state.

Mr. and Mrs. Carey subsequently initiated a lawsuit against the patient's internist and obstetrician as well as various other defendants. A jury returned a verdict against the two physicians. The plaintiffs appealed and the intermediate reviewing court concluded that the parents' claims for emotional distress were not supported by the facts.

15. *Id.* at 1282.

On further appeal, the New Jersey Supreme Court concluded that the case posed the question of whether parents, without attempting to prove physical injury to themselves, are entitled to recover for emotional distress caused by medical malpractice that resulted in the premature birth and death of their baby. In reaching a decision in the case, the court emphasized that it was concerned with the potential effects of expanded liability on the medical profession and society. Nevertheless, the court concluded that both the mother and father could recover for emotional distress under the facts of the case.[16]

The court observed that mother and fetus are interconnected and the mother is more than a mere bystander. A woman who has been told that her fetus is dead, but then learns that it was born alive but impaired, has sustained the type of severe emotional trauma that merits compensation.[17] With respect to the father, if he occupies an intimate family relationship to the mother and baby and suffers severe emotional distress from witnessing the malpractice and its effect on the baby, he is also entitled to recover damages.[18] Thus, despite the court's recognition that decisions of this nature have the potential to expand liability for medical malpractice in our society, the facts of the case justified recovery for severe emotional distress, even in the absence of physical injury to the parents.[19]

The *Carey* decision evidences an expanded notion of physician accountability in the context of medical malpractice litigation. A similar judicial extension of physician accountability is seen in a December, 1992 decision of the Supreme Court of Indiana. In *Walker v. Rinck*,[20] the court ruled that a physician owes a duty to future children of an Rh-negative woman who gives birth to an Rh-positive child.

In October of 1975, the patient's obstetrician informed her that she was pregnant. The patient notified him that she had Rh-negative blood and he ordered blood tests, which erroneously reported that the patient had Rh-positive blood. As a result, in June of 1976, when her first child was born with Rh-positive blood, no RhoGAM[21] injections were given to the pa-

16. *Id.* at 1288.
17. *Id.* at 1286-87.
18. *Id.* at 1287.
19. *Id.* at 1287-88.
20. 604 N.E.2d 591 (Ind. 1992).
21. RhoGAM is used to prevent the formation of antibodies in situations where an Rh-negative pregnant woman gives birth to a child with Rh-positive blood. In the

tient. The plaintiff's body then formed antibodies to Rh-positive blood. Five years later, the plaintiff gave birth to a second child who had Rh-positive blood. The child suffered from anemia and respiratory problems. Twins were born four years later, one of whom had Rh-positive blood. This child suffered hearing impairments, motor skill deficiencies, and possible mental retardation. The other twin, who had Rh-negative blood, suffered from asthma.

All three children sued the obstetrician and the clinical laboratory that tested the blood, alleging that the defendants' negligence prior to and at the time of the birth of the mother's first child in 1976 injured them. The defendants filed motions for summary judgment, which the trial court granted based, among other things, on Indiana's refusal to recognize a preconception cause of action. Following appellate court review, the case was considered by the Supreme Court of Indiana.[22]

The defendant obstetrician argued that he did not owe a duty to the children because no physician-patient relationship ever existed between them. However, the court noted that there is a well-established medical practice of administering RhoGAM to Rh-negative mothers who give birth to Rh-positive children to protect future children from clearly foreseeable injury. Because the Walker children were beneficiaries of their mother's relationship with her physician, the court concluded that public policy favored the existence of a duty on the part of the obstetrician toward the children to use reasonable care regarding administration of RhoGAM to the mother. Despite claims by the defendants that allowing this action to proceed would "add fuel to the burning medical crisis in the State of Indiana,"[23] the court concluded that to preclude the Walker children from seeking compensation for their injuries, which were a foreseeable consequence of the negligence of the defendants, would be contrary to fundamental principles of tort law.[24]

Similar claims by physician defendants that traditional tort liability should not be extended beyond manageable bounds were

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event of subsequent pregnancy, these antibodies may cause serious injury to a child born with Rh-positive blood. *See* J. E. SCHMIDT, ATTORNEYS' DICTIONARY OF MEDICINE AND WORD FINDER R-92 (1988).

22. In ruling on this case, the Indiana Supreme Court sought to resolve a conflict between the Third District Court of Appeals in *Walker* and the First District Court of Appeals in Yeager v. Bloomington Obstetrics, 585 N.E.2d 696 (Ind. Ct. App. 1992).

23. 604 N.E.2d at 596.

24. *Id.* at 595-97.

raised and rejected in the New York case of *Miller v. Rivard*.[25] There, the court relied on principles of foreseeability to rule that a physician may be held liable for a negligently performed vasectomy that results in injury to the patient's spouse, despite the absence of a physician-patient relationship between them. John Miller contacted the defendant urologist who performed a vasectomy in April of 1987. Subsequently, in June of 1987 and again in August of 1987, fertility tests were performed on Mr. Miller's semen. Following the second test, Mr. Miller telephoned the defendant's office and was advised by the nurse that the vasectomy was successful and that he and his wife could resume sexual relations without using contraceptive measures. The following spring, however, Mrs. Miller learned that she was pregnant. Subsequent fertility testing indicated that Mr. Miller was, in fact, still fertile. Even though Mrs. Miller gave birth to a healthy child, she suffered severe medical complications during pregnancy and delivery, and ultimately required additional surgery and a hysterectomy.

Both Mr. and Mrs. Miller filed a wrongful conception[26] suit against the urologist and other defendants for a variety of injuries. After the trial court dismissed two counts of the plaintiffs' complaint and the defendants' affirmative defense, the parties cross-appealed. The reviewing court focused on the question of whether Mrs. Miller had a legally cognizable cause of action against her husband's health care providers.

The defendants argued that in view of the lack of a physician-patient relationship between Mrs. Miller and her physician, allowing such a cause of action would constitute an unwarranted and unmanageable expansion of traditional tort principles. The court did not agree. Noting that the damages potentially recov-

25. 585 N.Y.S.2d 523 (N.Y. App. Div. 1992).

26. Wrongful conception lawsuits are commenced by the parents of a healthy, but unplanned, newborn child to recover for physical as well as financial injuries resulting from a negligently performed procedure, the purpose of which was the prevention of conception and childbirth. THEODORE R. LEBLANG & W. EUGENE BASANTA, THE LAW OF MEDICAL PRACTICE IN ILLINOIS 876-78 (1986). A wrongful conception claim differs from a wrongful birth claim, where parents seek damages on their own behalf for injuries sustained in connection with giving birth to a disabled child. In these cases, parents allege that as a result of medical malpractice, they were not informed about the potential to give birth to a disabled child (for example, because of an undiagnosed genetic predisposition or a physician's failure to perform or to properly perform appropriate prenatal testing). *Id.* at 879-80. Another related cause of action is the wrongful life claim. This claim is similar to the wrongful birth claim, but compensation for injuries is sought by the disabled child on its own behalf. *Id.* at 381-83 (Supp. 1993).

erable by Mrs. Miller would be precisely the same as those she would be able to recover if she had undergone an unsuccessful tubal ligation, the court observed that "[t]here is no sound reason in policy, fairness, or in the fulfillment of the role of tort law as a deterrent to negligent conduct" to distinguish the exposure to liability on the basis of the type of sterilization performed.[27]

The court concluded that imposing liability on Mr. Miller's health care providers for Mrs. Miller's damages, despite the absence of a physician-patient relationship, fell squarely within traditional tort principles. Because the avoidance of a potentially injurious fourth pregnancy was the essential purpose of Mr. Miller's election to undergo a vasectomy, it was foreseeable that if the physician performed the vasectomy negligently, then Mrs. Miller might suffer serious injuries if she became pregnant. Accordingly, the court ruled that it was appropriate to subject the defendants to liability.[28]

Cases like the ones discussed above exemplify the manner in which state courts have broadened physician accountability in the context of health care delivery, fostering increases in the frequency of medical malpractice litigation as well as the growing severity of medical malpractice settlements and awards. There is clear consensus that the costs of medical malpractice litigation have contributed significantly to escalating health care costs in the United States.

II. Legislative Responses

Perhaps the most obvious example of health care costs attributable to the medical liability system are the insurance premiums paid by physicians and hospitals for medical malpractice coverage.[29] When measured as a fraction of the total cost of physician services in this country, spending for medical malpractice liability insurance premiums grew from 3.1 percent in 1982 to 4.8 percent in 1989, totaling $5.6 billion.[30] More recent reports suggest that in 1991 these premiums reached a total of $9.1 billion, an increase of more than 60 percent over 1989.[31]

27. 585 N.Y.S.2d at 527.
28. *Id.*
29. Peter P. Budetti, *Malpractice and Access to Care,* 36 St. Louis U. L.J. 879 (1992). *See also* James W. Moser & Robert A. Musacchio, *The Cost of Medical Professional Liability in the 1980s,* J. Med. Prac. Mgmt., Summer 1991, at 6.
30. Budetti, *supra* note 29, at 881.
31. Sean Taylor Simpson, *Why We Can't Afford to Ignore Tort Reform,* Private Prac., June 1993, at 36, 40.

As a separate consideration, there is evidence that more than eight out of ten physicians practice defensive medicine in an attempt to protect themselves from being sued.[32] Among other things, the practice of defensive medicine includes ordering laboratory tests or other diagnostic procedures that are not medically necessary or indicated, but that enhance a physician's ability to successfully defend against a potential medical malpractice lawsuit.[33]

The amount of total health care costs for physician services that may be attributed to the practice of defensive medicine has been variously estimated to run between $4 billion and $25 billion per year.[34] One survey estimated the cost of defensive medicine at approximately $10 billion in 1991 and projected that this amount would increase to approximately $15 billion (in 1991 dollars) by 1998.[35]

Given the combined costs of professional liability insurance premiums and the costs attributable to the practice of defensive medicine, state and federal legislative proposals designed to limit physician exposure to professional liability will likely have an important impact in reducing total expenditures for physician services as well as overall costs of health care in this country.[36]

For example, California's landmark Medical Injury Compensation Reform Act of 1975 (MICRA) has long been considered the "gold standard" in legislation intended to limit escalating insurance premiums and the costs of defensive medical practice.[37]

MICRA has four primary components. First, it places a $250,000 limit on the amount of noneconomic damages that may

32. Gastel, *supra* note 1; Moser & Musacchio, *supra* note 29, at 8.

33. Budetti, *supra* note 29, at 883.

34. Edward Felsenthal, *Cookbook Care: Maine Limits Liability for Doctors Who Meet Treatment Guidelines,* WALL. ST. J., May 3, 1993, at A1.

35. Kenneth Vatz, *Caps Would Help*, ILL. MED., May 21, 1993, at 7 (citing a study conducted by the National Medical Liability Reform Coalition). *See also* Gastel, *supra* note 1 (citing the same study). At this writing, the United States Congress Office of Technology Assessment is conducting a comprehensive study to evaluate the impact of defensive medicine on health care costs. As this article went to press, the final report was released. OFFICE OF TECHNOLOGY ASSESSMENT, UNITED STATES CONGRESS, DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE (OTA-M-602, July 1994).

36. *See* Moser & Musacchio, *supra* note 29; A. Russell Localio et al., *Relationship Between Malpractice Claims and Cesarean Delivery,* 269 JAMA 366 (1993).

37. Brian McCormick, *Draft Plan Offers Some Tort Relief*, AM. MED. NEWS, Sept. 27, 1993, at 1. *See also* OFFICE OF TECHNOLOGY ASSESSMENT, UNITED STATES CONGRESS, IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS (OTA-BP-H-119, Oct. 1993); James Todd, *Reform of the Health Care System and Professional Liability*, 329 NEW ENG. J. MED. 1733 (1993).

be awarded to a medical malpractice plaintiff.[38] Second, MICRA limits attorneys contingency fees based upon a sliding scale—attorneys can receive 40 percent of the first $50,000 of an award, 33 1/3 percent of the next $50,000, 25 percent of the next $500,000, and 15 percent of any amount over $600,000.[39] Third, MICRA provides that juries may be informed of the amount payable to a plaintiff from collateral sources (such as health insurance, disability coverage, workers' compensation, and other third-party payers).[40] Juries are then permitted to exercise discretion in deducting collateral source payments when making their damage award to the plaintiff. Finally, MICRA provides for periodic payment of future damages in excess of $50,000 (such as medical treatments, loss of earnings, and noneconomic damages).[41] Under this provision, insurance companies are able to purchase an annuity and pay out large judgments over an extended period of time rather than make a lump sum cash payment to the plaintiff.

As a result of the implementation of MICRA, medical malpractice insurance premiums for physicians in California declined approximately 38 percent from 1976 to 1991, when adjusted for inflation.[42] As of 1992, liability insurance premiums for California physicians were one third to one half of the amounts paid by physicians in states that failed to enact such reforms.[43]

Against the background of these statistics, as well as information from other states that enacted similar reforms, commentators have observed that caps on noneconomic damages are the most significant factor in holding down medical malpractice insurance rates.[44] Currently, approximately twenty states have some type of cap on economic and/or noneconomic damages.[45] Moreover, nearly every state has enacted at least some mini-

38. CAL. CIV. CODE § 3333.2 (West Supp. 1994). Noneconomic damages compensate individuals for pain and suffering, while economic damages compensate for such things as past and future medical treatment costs and lost wages and/or profits, as well as projected lost earnings.

39. CAL. BUS. & PROF. CODE § 6146 (West 1990).

40. CAL. CIV. CODE § 3333.1 (West Supp. 1994).

41. CAL. CIV. PROC. CODE § 667.7 (West 1987).

42. Gastel, *supra* note 1.

43. CALIFORNIANS ALLIED FOR PATIENT PROTECTION, MICRA INFORMATION (Jan. 1, 1993).

44. *See* Gina Kimmey, *Caps at Work in California*, ILL. MED., Sept. 10, 1993, at 9; OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 37, at 64.

45. *See* CENTER FOR HEALTH POLICY RESEARCH, THE GEORGE WASHINGTON UNIVERSITY, COMPENDIUM OF STATE SYSTEMS FOR RESOLUTION OF MEDICAL IN-

mum level of tort reform.[46]

Given the importance of such reform in reducing medical malpractice liability insurance premiums and controlling the practice of defensive medicine, President Clinton has incorporated medical malpractice tort reform in his comprehensive strategy to reform the health care system. His 1993 Health Security Act[47] proposal includes the following recommended malpractice reforms.

Creation of Alternative Dispute Resolution Mechanisms

Each health plan would establish an alternative dispute resolution process using one or more of several models. Potential model systems include early offers of settlement, mediation, and arbitration. Consumers with a claim against a health care provider in the plan would be required to submit the claim to the plan's alternative dispute system; consumers who are not satisfied with the outcome could then pursue their claims in court.[48]

Requirement for a Certificate of Merit

Plaintiffs suing for injury from medical malpractice would be required to include with their complaint an affidavit signed by a medical specialist practicing in a field relevant to the claimed injury. The affidavit would indicate that a specialist examined relevant medical records and concluded that the medical procedures or treatments in question deviated from established standards of care.[49]

Limits on Attorneys' Fees

Attorneys' fees in medical malpractice cases would be limited to a maximum of 33 1/3 percent of the total award. States could impose lower limits.[50]

JURY CLAIMS (Stephanie Spernak & Peter Budetti, eds. 1991); AMERICAN TORT REFORM ASSOCIATION, TORT REFORM RECORD (June 30, 1993); OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 37, at 26-27.

46. OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 37, at 26-27.

47. H.R. 3600, 103d Cong., 1st Sess. (1993) (introduced Nov. 20). Given the ongoing debate regarding health care reform and the President's Health Security Act, it is appropriate to consider the recommended malpractice reforms listed herein as examples, for purposes of discussion, rather than as likely provisions of any public law that may eventually be enacted.

48. *Id.* at § 5302.

49. *Id.* at § 5303.

50. *Id.* at § 5304.

Collateral Sources

A medical malpractice award would be reduced by any amounts recovered by a plaintiff from external sources such as health insurance, workers' compensation payments, disability insurance, or any other programs designed to compensate the plaintiff for the same injury.[51]

Periodic Payment of Awards

Parties to a medical malpractice case could request that an award be made payable in periodic installments, as appropriate, to reflect past and future needs for medical and other related services.[52]

Enterprise Liability Demonstration Project

Federal monies would be allocated to support state demonstration projects to establish enterprise liability. These projects would be designed to determine whether substituting physician liability with liability on the part of a health service plan would lead to an improvement in the quality of care, reduction in the practice of defensive medicine by physicians, and improved risk management.[53]

Standards Based on Practice Guidelines

The Department of Health and Human Services would develop a medical liability pilot program based on practice guidelines. Under this system, a physician would be permitted to demonstrate that his or her professional conduct or treatment complied with appropriate practice guidelines, thus providing a defense in a medical malpractice lawsuit. The Department would be given authority to work with the states to invest practice guidelines with the force of law to protect physicians and other health care providers participating in the pilot program.[54]

The medical malpractice tort reform measures contained in President Clinton's Health Security Act proposal have gener-

51. *Id.* at § 5305.
52. *Id.* at § 5306.
53. *Id.* at § 5311.
54. *Id.* at § 5312.

ated considerable debate.[55] Some have argued that without capping noneconomic damages in medical malpractice cases, tort reform cannot succeed in reducing health care costs and alleviating the need for physicians to engage in the practice of defensive medicine.[56] However, others have observed that despite the absence of caps on noneconomic damages, President Clinton's proposal regarding practice guidelines may have the greatest potential to reduce health care costs and eliminate defensive medical practice.

The Maine Medical Liability Demonstration Project,[57] which became effective in 1992, has shown that the use of practice guidelines significantly influences physician conduct when protections are afforded to physicians who comply with them.[58] Committees composed largely of physicians prepare practice guidelines in the specialties of obstetrics/gynecology, radiology, emergency medicine, and anesthesiology. The guidelines take effect if more than one half of all physicians practicing in the specialty choose to participate. Physicians who have notified the Board of Registration in Medicine of their election to participate in the project are permitted to prove that they have complied with established parameters as an affirmative defense in any medical malpractice lawsuit.[59]

As of May, 1993, Maine had issued 22 sets of checklists advising physicians on how to handle different patients under different circumstances. Emergency room officials at Maine Medical Center estimated that, as a result of these checklists, approximately 50 percent of victims of falls or automobile accidents received neck x-rays costing $170, compared with about 95

55. *See* Brian McCormack, *Hitting Tort Issues in Reform,* AM. MED. NEWS, April 25, 1994, at 1. It is of interest to note that in its 1994 report to Congress, the Physician Payment Review Commission advocated tort reform, including the following: noneconomic damage limits; collateral source offset; limitation of attorneys' contingency fees; shorter statutes of limitations; use of binding alternate dispute resolution methods; and periodic payments of awards. PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REPORT TO CONGRESS 289 (1994). Certificates of merit and practice guidelines in malpractice cases were not included in the list of recommendations due to a lack of current knowledge regarding potential effectiveness. *Id.*

56. *See* Arthur R. Traugott, *Caps Are Cornerstone of Tort Reform,* ILL. MED., Sept. 24, 1993, at 4.

57. These provisions were enacted as part of the Maine Health Security Act. ME. REV. STAT. ANN. tit. 24, §§ 2971-79 (West Supp.1993).

58. *See* Felsenthal, *supra* note 34. For a detailed discussion of the Medical Liability Demonstration Project in Maine, see UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: MAINE'S USE OF PRACTICE GUIDELINES TO REDUCE COSTS (GAO/HRD-94-8, Oct. 1993).

59. ME. REV. STAT. ANN. tit. 24, § 2975 (West Supp. 1993).

percent of victims before the practice guidelines went into effect.[60]

Since the time that Maine enacted this legislation, the states of Florida,[61] Minnesota,[62] and Vermont[63] also have enacted legislation giving practice guidelines legal effect.[64] Florida and Minnesota established mechanisms that permit the development of practice parameters and authorize physicians to use compliance with the guidelines as an affirmative defense in malpractice litigation.[65] In Vermont, guidelines will be developed for use as evidence regarding the standard of care in claims that are resolved under the state's arbitration system.[66]

Numerous other states are currently considering similar legislation, and practice guidelines are now being created by federally sponsored panels, medical specialty and subspecialty societies, state governments, third-party payers, health maintenance organizations, hospitals, and various other entities.[67] In fact, from 1990 through 1992, the number of guidelines indexed by the American Medical Association increased from 700 to over 1300.[68] If practice guidelines continue to be developed, then it is reasonable to anticipate that physician compliance with guidelines will reduce the frequency and severity of medical malpractice claims while, at the same time, improving the quality of care and reducing defensive medical practice.[69]

CONCLUSION

This evaluation of significant recent developments affecting

60. Felsenthal, *supra* note 34.

61. FLA. STAT. ANN. § 408.02 (West Supp. 1994).

62. MINN. STAT. ANN. § 62J.34 (West Supp. 1994).

63. VT. STAT. ANN. tit. 12, § 7003 (Supp. 1993).

64. Linda Oberman, *States Race to Whip Up Practice Guidelines; Too Many Cooks?* AM. MED. NEWS, Oct. 4, 1993, at 1. *See also* UNITED STATES GENERAL ACCOUNTING OFFICE, *supra* note 58, at 96.

65. *See* FLA. STAT. ANN. § 408.02; MINN. STAT. ANN. § 62J.34. *See also Three States' Guidelines Projects,* AM. MED. NEWS, Oct. 4, 1993, at 31.

66. *See* VT. STAT. ANN. tit. 12, § 7003. *See also Three States' Guidelines Projects, supra* note 65.

67. Richard N. Shiffman, *Clinical Guidelines in Medical Practice,* J. MED. PRAC. MGMT., Sept.-Oct. 1993, at 70. One recent publication advertises that it offers a compendium of over 23,000 health care standards, clinical practice guidelines, laws, and regulations. ECRI, HEALTHCARE STANDARDS (1994).

68. Shiffman, *supra* note 67.

69. *See* Deborah W. Garnick et al., *Can Practice Guidelines Reduce the Number and Costs of Malpractice Claims?*, 266 JAMA 2856 (1991). *See also* Edward B. Hirshfeld, *Practice Parameters and the Malpractice Liability of Physicians,* 263 JAMA 1556 (1990).

medical malpractice litigation in the United States shows that state courts continue to impose increasingly more significant obligations on physicians in the context of the physician-patient relationship. This is occurring, perhaps for the first time in the history of modern medicine, at precisely the same time that federal and state governments are pursuing efforts to control health care costs with extraordinary vigor.

The public policy favoring compensation for injured persons within the venerable American tort law system conflicts with the equally compelling public policy favoring universal access to affordable, quality medical care. Clearly, to achieve access to affordable health care in this country, there must be control of escalating health care costs—driven up, in part, by increasing medical malpractice insurance premiums and the high price of defensive medicine.

The precise shape of medical malpractice tort reform in this country remains to be seen. However, there can be little doubt that new legislation at the state and federal level will begin to have impact—probably significant impact—in reducing the frequency and severity of medical malpractice claims throughout the United States.