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Physician Retaliation: Can the Physician-Patient Relationship Be Protected?

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Physician Retaliation: Can the Physician-Patient Relationship Be Protected?

Once most people treated me as a friend and a confidant . . . . These days the malpractice threat has created a definite wedge between a physician and some of his patients.[1]

I. Introduction

A generation ago, physicians enjoyed the respect, trust, faith, and even love of their patients. In recent years, technological advances in medicine, medical specialization, medical consumerism, and threats of malpractice suits have all created tension in the doctor-patient relationship.[2]

Medical malpractice suits, in particular, have distanced doctors from their patients. In the wake of two decades of malpractice insurance crises,[3] doctors began practicing "defensive medicine."[4] Now some doctors choose not to treat certain patients at all.[5] Other times doctors agree to treat, but impose certain "ground rules" that the patient must agree to before treatment will begin.[6]

Express contractual agreements increasingly create and control the physician-patient relationship.[7] In an effort to reduce exposure to malpractice liability, some health care practitioners employ contracts

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1. Gibbs, *Sick and Tired*, TIME, July 31, 1989, at 48 (quoting Boyd McCracken, Sr., M.D., a family practitioner from Greenville, Il.). Dr. Boyd recalls the days when he made late-night house calls. *Id.*

Today, malpractice lawsuits create emotional stress in the physician-patient relationship and within physicians' lives. *See* Charles, Wilbert & Kennedy, *Physician Self-Reports of Reactions to Malpractice Litigation*, 141 AM. J. PSYCHIATRY 563, 565 (1984) ("A malpractice suit [is] considered a serious and often a devastating event in the personal and professional lives of the respondent physicians.").

2. Gibbs, *supra* note 1, at 49.

3. For discussions about the malpractice insurance crises of the 1970s and 1980s, see generally Gastel, *Medical Malpractice*, INS. INFO. INST., Oct. 1989 (Lexis, Nexis library, Omni file); Nye, Gifford, Webb & Dewar, *The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L.J. 1495 (1988) [hereinafter *Malpractice Crisis*].

4. *See infra* notes 64-72 and accompanying text.

5. *See infra* notes 21-42, 54-62 and accompanying text.

6. *See infra* notes 80-81, 164-66 and accompanying text.

7. Express contracts control the physician-patient relationships in Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's), and Individual Practice Associations (IPA's). These organizations offer an alternative to the traditional fee-for-service approach to health care. For a consideration of the contract issues raised by alternative medical practice forms, *see* J. Lemkin, *Alternative Delivery Systems: HMOs, PPOs, and CMPs*, in R. MCNAIR, HEALTH CARE, LEGAL RESPONSES TO NEW ECONOMIC FORCES (1985). This Comment is limited to the contracts promulgated by private fee-for-service physicians.

that expressly modify patients' legal rights.[8] One type of contract attempts to limit the amount of legal assistance a physician gives to a patient, both during and after treatment.[9] Doctors who employ this contract hope to discourage litigious patients from seeking their medical services.

Doctors may also try to avoid malpractice liability by refusing to treat certain patients altogether. These doctors attempt to circumvent legal confrontation by refusing to treat laywers,[10] persons who have been involved in past litigation,[11] and "high risk" individuals such as obstetrical patients.[12]

The steep rise in professional malpractice insurance costs[13] angers medical providers. Opinions differ as to where the blame for the problem lies.[14] Many doctors consider lawyers to be responsible for their costly insurance bills. These physicians believe that lawyers bring frivolous malpractice claims solely to make money and they do so without regard for the effects lawsuits have on insurance rates.[15] In an attempt to "get even" with attorneys, some doctors refuse to cooperate with the legal process on behalf of a treated patient.[16] Unfortunately, it is the patient who is punished, rather than the attorney.

This Comment explores the measures doctors have taken to avoid both liability litigation and involvement in the legal process. The Comment focuses on the effects these actions have had on patient treatment, patient rights, and physician-patient relationships. The Comment concludes with suggestions to help reduce the antagonism found between doctors and lawyers and to help protect the patient from becoming a pawn in the battle.

II. The Physician-Patient Relationship

A. Creation of the Relationship

Traditionally, the relationship between a doctor and patient is

8. *See infra* notes 79-80, 163-65 and accompanying text.
9. *See infra* note 80.
10. *See infra* notes 59-62 and accompanying text.
11. *See infra* notes 23-38 and accompanying text.
12. *See infra* notes 39-42, 53-58 and accompanying text.
13. The American Medical Association [hereinafter AMA] estimates that, on average, 15 percent of the total amount of revenue spent on physician services is attributable to rising liability costs. Gastel, *supra* note 3.
14. A number of candidates have been cited as the culprit: avaricious lawyers, negligent doctors, litigious patients, and greedy insurers. *Malpractice Crisis*, *supra* note 3, at 1497.
15. Interview with LeRoy Smigel, J.D., member of the Dauphin County Bar Association, Committee on Interprofessional Relations, in Harrisburg, Pa. (Sept. 20, 1989).
16. *Id.*

based upon an express or implied contract. A patient offers to enter into a contract by going to the doctor's office with a particular problem and the doctor accepts the offer by examining the patient.[17] Unlike parties in a traditional contract scenario, however, the patient and physician are not considered to be dealing at "arms length."[18] Instead, the physician is considered to have greater bargaining power as a result of superior knowledge. Therefore, the law imposes certain obligations upon doctors that are not imposed upon patients.[19]

Once established under contract law, the doctor-patient relationship is regulated primarily by tort law.[20] Yet, many doctors are now turning to contract principles in an attempt to restrict the common law parameters of tort regulations.

B. Duty To Treat: Taking Advantage of the "No Duty" Rule

It is well settled that, in the absence of an implied or express contract, a physician is under no initial duty to treat a person requiring medical services.[21] This common-law rule applies even in emergency situations.[22] Doctors can refer to the rule as their grant of authority for refusing to treat certain patient groups including indigents, lawyers, obstetrical patients, and those who have been party to

17. This interchange creates an implied contract, the most common contract between patients and fee-for-service physicians. Whether a physician-patient relationship has been created is a question of fact, and courts have been quite flexible in determining that an implied contract has been formed. *See, e.g.*, Hiser v. Randolph, 126 Ariz. 608, 617 P.2d 774 (Ct. App. 1980) (accepting "on-call" status in hospital imposes duty of care); O'Neill v. Montifiore Hosp., 11 A.D.2d 132, 202 N.Y.S.2d 436 (1960) (doctor who talks with patient on telephone creates implied contractual obligation to patient); Lyons v. Grether, 218 Va. 630, 239 S.E.2d 103 (1977) (physician-patient relationship was established merely by the scheduling and acceptance of an office appointment). *See also* Annotation, *What Constitutes Physician-Patient Relationship For Malpractice Purposes*, 17 A.L.R. 4TH 132 (1982).

18. Doctors are expected to act as fiduciaries in their dealings with patients. *See* Witherell v. Weimer, 85 Ill. 2d 146, 421 N.E.2d 869 (1981), *rev'd on other grounds*, 118 Ill. 2d 321, 515 N.E.2d 68 (1987); Louden v. Mhyre, 110 Wash. 2d 675, 756 P.2d 138 (1988).

19. These obligations include a duty to use a particular standard of care and a duty not to terminate the relationship except under certain circumstances. *See infra* notes 74-76 and accompanying text.

20. For a historical discussion of tort law control over the patient-physician relationship, see Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 LAW & CONTEMP. PROBS. 287 (Spring 1986).

21. Hurley v. Eddingfield, 156 Ind. 416, 59 N.E. 1058 (1901); Childs v. Weis, 440 S.W.2d 104 (Tex. Civ. App. 1969).

22. There is no legal duty to treat in an emergency situation, although there is an ethical duty to treat. The AMA has established a code of medical ethics which suggests that a physician should treat an individual when an emergency arises. *See* AMA, PRINCIPLES OF MEDICAL ETHICS, Principle VI (1980).

In addition, 49 states and the District of Columbia have adopted Good Samaritan statutes. These statutes protect health care professionals who render emergency aid from civil liability for damages if they cause any injury. *See generally* Annotation, *Construction and Application of "Good Samaritan" Statutes*, 68 A.L.R. 4TH 294 (1989).

litigation. Fear of litigation may be the primary reason why doctors turn these patients away.

1. "Litigious" patients.—In 1985, *Physician's Alert*, a private computerized service that identifies patients who have filed lawsuits, began accepting subscribers in Detroit, Chicago, and Los Angeles.[23] Since then, the service has expanded nationally.[24] The service data base includes lawsuits filed for medical malpractice, products liability, and personal injury.[25] *Physician's Alert* was established to "[eradicate] the adversarial aspects of the doctor-patient relationship so that doctors will feel more comfortable treating patients."[26] Turning potentially litigious patients away, or charging them more to cover possible malpractice costs,[27] can make physicians feel better protected from the brunt of a malpractice claim.

Physician's Alert founders have no concern about potential ethical abuses of the service by doctors since the service makes no judgment or recommendation about the validity or merit of cases reported.[28] Likewise, there is little concern about violation of patients' privacy rights because the service data base consists of matters that are of public record.[29]

Opponents and proponents of *Physician's Alert* have debated the propriety of the service under the strictures of the Hippocratic Oath.[30] Those opposed to the service argue that the Oath does not allow discrimination against persons who have filed lawsuits.[31] Those in favor of the service point out that the Oath requires doctors to

23. Tapp, *Service Allows Doctor to Screen Plaintiff-Patients*, Chi. Daily L. Bull., Mar. 19, 1985, at 1, col. 2; Shwiff, *Service Promises to Help Physicians Identify Plaintiffs*, L.A. Daily J., Oct. 23, 1985, at 1, col. 2. For a fee, doctors can call *Physician's Alert* to find out in a matter of seconds whether a potential patient has ever filed a lawsuit. When the Los Angeles County Medical Association announced it would subscribe to the service, the Los Angeles Trial Lawyers Association voted to set up a telephone hotline to help consumers find out how many times their doctors have been sued for malpractice. *See* Frank, *Tit for Tat?*, A.B.A. J., Feb. 1986, at 22; Galante, *Doctors, Attorneys Feud Over 'Hotline' in Calif.*, NAT'L L.J., Dec. 2, 1985, at 9, col. 1.

24. *Physician's Alert* serves Colorado, Dallas, Miami, and New York. Elmer-Dewitt, *An Electronic Assault on Privacy?*, TIME, May 19, 1986, at 13.

25. Shwiff, *supra* note 23. The data base does not include divorce or child custody cases. *Id.* In Los Angeles, subscribers are referred to *Apograph*, a Los Angeles based company that will further research the cases for additional fees. *Id.*

26. Tapp, *supra* note 23, at 14, col. 6 (quoting Paul H. Huth, founder of *Physician's Alert*).

27. *Id.*

28. *Id.*

29. For an informative examination of privacy issues in the computer age, see D. LINOWES, PRIVACY IN AMERICA (1989).

30. *See* Shwiff, *supra* note 23; Galante, *supra* note 23.

31. Galante, *supra* note 23.

treat anyone in an emergency situation, so the service does not prevent seriously ill or injured patients from receiving treatment.[32]

The potential abuses feared by the use of *Physician's Alert* at its inception have not materialized. Early surveys of *Physician's Alert* subscribers show that only a small number of users have refused to treat people whose names appeared as plaintiffs.[33] In addition, the Los Angeles County Medical Association ended its promotional agreement with the hotline not long after the agreement was made, due to a lack of response.[34] The Association admits that it is still concerned about malpractice suits, but claims that "most [Los Angeles] doctors . . . aren't interested in turning patients away."[35]

Abuse of data bases like *Physician's Alert* is possible because of the nature of such systems. Few laws regulate the quality and accuracy of data bases in general.[36] Regulations that do exist generally do not reach the private use of electronic information.[37] Although Congress and state legislatures are beginning to protect personal information privacy, lawsuits and other matters of public record will probably receive minimal, if any, protection.

Although *Physician's Alert* seems to have lost physician support, doctors continue to express an aversion to treating potential litigants.[38] If this attitude persists, individuals that have been party to

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32. Shwiff, *supra* note 23. Actually, the Hippocratic Oath does not require physicians to treat in an emergency. The Oath, once considered the *sine qua non* of medical ethics, is now regarded as merely an "interesting antique." *See* C. CHAPMAN, PHYSICIANS, LAW AND ETHICS 25 (1984). In ancient times, physicians were craftsmen. *Id.* The concept of ethics implicit within the Oath operated only as a source of guidelines for members of the medical trade. *Id.* In modern times, medical professional organizations recognize the problems of individualism in the Oath. The new medical ethical codes provide for the needs of patients and society, as well as physicians. *See, e.g.*, AMA, PRINCIPLES OF MEDICAL ETHICS (1980). Today, physicians who base ethical decisions on the Hippocratic Oath open themselves to any number of sanctions, both legally and professionally.

33. Shwiff, *supra* note 23. About two percent of the doctors surveyed in Detroit refused to treat prior litigants. *Id. Physician's Alert* founder Michael Eckstein was not aware of any situation in which an individual was denied medical treatment because of a "computer blacklist." Elmer-Dewitt, *supra* note 24, at 14.

34. Pasternak, *Physicians Hang Up On Legal Hot Line*, L.A. Times, Sept. 14, 1986, Metro Section Part 2, at 1, col. 2 (home ed.).

35. *Id.* (quoting David Zeitlin, Director of Communications, Los Angeles County Medical Association). A physician glut in large cities is one reason some doctors are reluctant to turn patients away. *Id.*

36. For federal statutory regulations, see Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552(a) (1988). For state statutory regulations see, e.g., Information Practices Act of 1977, CAL. CIV. CODE §§ 1798-1798.78 (Deering 1981 & Supp. 1990); Privacy Protection Act of 1976, VA. CODE ANN. §§ 2.1-377.1 to -386 (1987 & 1989 Supp.).

37. One exception is the federal Video Privacy Protection Act of 1988, 18 U.S.C. § 2710 (1988), which bars retailers from selling or disclosing video rental records without a customer's permission. For a review of the current federal laws designed to protect personal information privacy, see Rothfeder, *Is Nothing Private?*, BUS. WK., Sept. 4, 1989, at 74.

38. Whether they use *Physician's Alert* or not, doctors are still trying to identify poten-

any type of litigation will find it harder to gain access to health care.

2. Obstetrical Patients.—A 1988 survey conducted by the American College of Obstetricians and Gynecologists indicates "that one out of eight physicians specializing in obstetrics has stopped delivering babies due to the threat of malpractice suits."[39] In Florida,[40] one in four obstetricians has left the field.[41] Earlier studies suggest that rural areas suffer the most as a result of this exodus.[42]

Obstetrics is a "high-risk" specialty[43] with extraordinarily high insurance premiums.[44] Well-respected physicians have been forced out of practice by the financial burden of malpractice costs.[45] Proposed and implemented solutions to the problem focus on reducing medical malpractice insurance costs.[46] The implemented solutions have already begun to ease the crisis. For example, recent tort reform measures have resulted in fewer malpractice claims[47] and lower jury awards for damages.[48] This, in turn, has helped to check the rapid increases in malpractice premiums. Several major insurers have, for the first time in more than a decade, reduced their premiums.[49]

Proposals that seek to encourage doctors to return to practice include: (1) controlling the legal costs of suits;[50] (2) spreading the

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tial plaintiffs. "It really dictates what happens at the office. If I feel I have people who are litigious, I prefer not to take them as patients." Linda Bolton, M.D., a pediatrician in Birmingham, Mich., *quoted in* Gibbs, *supra* note 1, at 52. Even before *Physician's Alert* existed, doctors sometimes refused to treat patients who were known to sue. One woman from Joliet, Illinois who filed a malpractice suit was subsequently denied treatment by 30 other physicians. Elmer-Dewitt, *supra* note 24, at 14.

39. Gastel, *supra* note 3 (reporting survey results). *See also Our Delivery Practice is Faltering*, PEOPLE, June 9, 1986, at 36 [hereinafter *Delivery Practice Faltering*].

40. Florida has the highest malpractice insurance premiums of all 50 states. *See generally Malpractice Crisis*, *supra* note 3; Gastel, *supra* note 3.

41. *Delivery Practice Faltering*, *supra* note 39, at 36.

42. Gastel, *supra* note 3 (reporting study findings); *Delivery Practice Faltering*, *supra* note 39, at 37-39.

43. Other "high risk" specialties include neurology and anesthesiology. *See Delivery Practice Faltering*, *supra* note 39, at 40-41.

44. Ob/gyn specialists were expected to pay an average of $72,439 in insurance premiums for the year 1986-1987, about 23 percent of their gross revenues. *See Malpractice Crisis*, *supra* note 3, at 1506-07.

45. *Delivery Practice Faltering*, *supra* note 39, at 38-39.

46. *Id.* at 40-41. *See also* Gastel, *supra* note 3.

47. *See* Gastel, *supra* note 3. A second reason for fewer malpractice claims is that physician-owned insurance companies are exposing incompetent doctors more quickly than state boards do. *See* Schwartz & Mendelson, *The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence*, 262 J. A.M.A. 1342 (1989). There are obvious financial incentives in preventing negligent colleagues from generating malpractice suits.

48. Gastel, *supra* note 3.

49. *Id.*

50. *Id.* (citing an April 1988 report from the New York Department of Insurance).

malpractice costs of high-risk specialties;[51] and (3) creating cost differentials for malpractice insurance depending upon a physician's geographic location.[52] When doctors feel less threatened by the risk of significant financial losses and professional humiliation, they will feel more comfortable about remaining in high-risk specialties.

3. Other Victims.—Indigent patients create liability risks,[53] yet physicians are unable to cover their liability insurance costs because there is no compensation for their services. Thus, many physicians have limited or discontinued the provision of gratuitous services.[54] Some state legislatures have attempted to remedy this denial of access to health care. These legislatures have passed laws that provide immunity from tort liability for physicians who provide free health care services, unless the care was grossly negligent.[55]

Indigents and other patients frequently seek medical care from academic health centers. University-sponsored health care centers conduct the majority of the nation's clinical research and offer patients state-of-the-art technology.[56] Due to rising medical malpractice insurance costs, doctors have increased referrals of high-risk patients to specialists, who in turn refer the patients to teaching clinics.[57] These clinics are at the end of the referral chain, and may likewise begin refusing treatment to certain patients out of fear of malpractice claims.[58]

Finally, many lawyers must seek medical care outside of their hometown or practice areas because local doctors will not accept them as patients.[59] Not surprisingly, doctors often refuse to treat lawyers that have filed malpractice claims against them.[60] In addition, doctors also refuse to treat the attorneys' families and employ-

51. *Id.*

52. *Delivery Practice Faltering*, *supra* note 39, at 41 (statement of consumer advocate Robert Hunter).

53. Benson v. Mays, 245 Md. 632, 227 A.2d 220 (1967) (duty of a physician to exercise ordinary care when treating a patient arises regardless of whether services are rendered gratuitously or for consideration).

54. *See generally* 16 STATE HEALTH LEGIS. REP. (May 1988).

55. *See, e.g.*, ARIZ. REV. STAT. ANN. § 12-571 (Supp. 1989); FLA. STAT. § 768.13 (1986 & Supp. 1989); GA. CODE ANN. § 51-1-29.1 (Harrison Supp. 1987); ILL. REV. STAT. ch. 111, ¶ 4405 (1978); ME. REV. STAT. ANN. tit. 24, § 2904 (Supp. 1989); S.C. CODE ANN. § 33-55-210 (Law. Co-op. 1987); VA. CODE ANN. § 54.1-106 (1988 & Supp. 1989).

56. *See* Gastel, *supra* note 3.

57. *See* Challoner, Kilpatrick, Dockery & Dwyer, *Effects of the Liability Climate on the Academic Health Center*, 319 NEW ENG. J. MED. 1603, 1604 (1988).

58. *Id.*

59. *See* Hengstler, *MDs Won't Deliver*, A.B.A. J., July 1, 1986, at 20.

60. *Id.*

ees.[61] Even though a lawyer never filed a suit against a particular doctor, the doctor still may refuse to treat the lawyer.[62] Occasionally, doctors will not administer treatment to someone who has sued one of the doctor's colleagues.[63]

C. *Standard Of Care: Leave No Stone Unturned*

Physicians may decide to treat a patient who has previously filed a lawsuit, but will order additional tests, prescribe more treatment, and keep more notes on the patient.[64] This phenomenon is termed "defensive medicine."[65] Currently, defensive medical practices are creating conflicts between consumers and the medical profession.

A recent Gallop Poll revealed that seventy-five percent of the responding physicians believe that fear of malpractice suits causes them to order more clinical tests than they believe are necessary.[66] A companion public opinion poll showed that sixty-one percent of the consumers questioned believe doctors do perform too many tests.[67]

Understandably, doctors believe widespread testing offers significant protection against malpractice claims. Failure to diagnose has been a classic basis for negligence actions against physicians. The additional precautions, however, have become costly. In 1985, about $15 billion was spent on defensive medicine.[68] These expenditures included time-consuming, uncomfortable procedures. For instance, obstetricians began to deliver babies by caesarean section because this procedure can be less risky than vaginal delivery.[69] Today, about one-fourth of all births are by caesarean section.[70]

Plaintiff's attorneys believe that the added precaution has brought medical care to a more acceptable level.[71] Actually, consum-

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61. *Id.*
62. *Id.*
63. *Id.*
64. Gibbs, *supra* note 1, at 52.
65. *See generally* Gibbs, *supra* note 1.
66. Gastel, *supra* note 3 (telephone poll of 1,000 physicians conducted by the Gallup Organization and sponsored by the AMA).
67. *Id.* Fifteen hundred randomly selected United States residents over 18 years of age were polled. Other findings from the Gallup surveys indicate: (1) "Forty-eight percent of the public believe that 'people who sue physicians for malpractice are just looking for an easy way to make money; (2) fifty-four percent think that malpractice awards . . . are too high; and (3) sixty-two percent of the public support capping pain and suffering awards." *Id.*
68. *See* Burda, *Liability Reshapes Hospital/Physician Relationships*, HOSPITALS, Apr. 5, 1987, at 56, 59.
69. Gibbs, *supra* note 1, at 53.
70. *Id.*
71. *See generally* Saks, *In Search of the 'Lawsuit Crisis'*, 14 LAW, MED., & HEALTH CARE 77 (1986) (discussing the theory that medical malpractice suits have targeted truly neg-

ers are realizing that defensive medicine may create a false sense of security to all parties concerned.[72] The public, once in favor of thorough medical testing, now wants less testing and more explanation.[73]

III. The Duty to Maintain the Physician-Patient Relationship: Modification by Contract?

A. Duty Not to Abandon Treatment

Once the doctor-patient relationship has been established, the treating physician is under a general legal duty to not abandon treatment.[74] Under certain circumstances, however, a physician may legally terminate the relationship. For example, a doctor and patient can mutually agree to end their contract. A physician may also terminate the relationship after providing the patient with reasonable notice of termination[75] and the opportunity to locate acceptable substitute care.[76]

B. Contracts for Medical Abandonment: Can Physicians Terminate Patient Treatment if Legal Assistance is Requested?

Physicians and patients can expressly agree to limit the amount of health care services to be provided.[77] A new question in health care law is whether freedom of contract allows physicians to legally and ethically terminate patient treatment when a patient who becomes involved in litigation asks for the physician's litigation assistance. Since this is a novel issue, case law addressing the question is sparse. Some cases raise analogous issues,[78] but the legal boundaries are only beginning to form.

An example from Pennsylvania exemplifies this novel question in the doctor-patient relationship. Some Pennsylvania physicians,

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ligent doctors).

72. *See* Harns, *Defensive Medicine: It Costs, But Does it Work?*, 257 J. A.M.A. 2801 (1987) (failure to follow up test results creates an even greater source of liability).

73. Gibbs, *supra* note 1, at 50 (45% of the 1,012 American adults surveyed by TIME/CNN on April 4-5, 1989 believe that doctors do not explain enough about procedures).

74. *See generally*, Comment, *Medical Abandonment*, 31 MED. TRIAL TECH. Q. 306 (1985).

75. Termination is usually accomplished by registered mail, return receipt requested. *See* Hirsh, *Dispatching Unwanted Patients*, LEGAL ASPECTS OF MED. PRAC., Jan. 1986, at 7.

76. Lee v. Dewbre, 362 S.W.2d 900 (Tex. Civ. App. 1962); Ricks v. Budge, 91 Utah 307, 64 P.2d 208 (1937). *See also* Payton v. Weaver, 131 Cal. App. 3d 38, 182 Cal. Rptr. 225 (1982) (unmanageable, uncooperative, and self-destructive behavior on part of patient is grounds for patient termination).

77. This contractual arrangement is most commonly promulgated under HMO, PPO, and IPA contracts. *See supra* note 7.

78. *See infra* notes 82-107.

practicing in high-risk specialties,[79] require patients to sign a new type of consent form. Simply stated, the document informs patients that the physician will provide copies of the patient's medical records upon written request and patient authorization. The doctors refuse to provide letters, reports, depositions, or otherwise "assist[] patients in developing lawsuits."[80] One form warns patients that medical treatment will be terminated if the patient insists upon cooperation from the doctors.[81] The patient's signature on these consent forms indicates agreement with the terms and conditions of treatment.

When a patient tries to obtain the physician's litigation assistance, regardless of the type of litigation the patient is pursuing, these contracts are invoked. The contracts raise a number of concerns.

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79. Neurological surgery and orthopedics are the practice areas focused upon.

80. The forms read in full:

CUMBERLAND ORTHOPAEDIC ASSOCIATES, LTD.

Our primary concern is the medical care and treatment of our patients, not assisting patients in developing lawsuits. It is becoming increasingly difficult for us to comply with the numerous requests for reports from patients and their attorneys. Consequently, please be advised that we will no longer prepare written reports for a patient's attorney or others concerning a patient's condition, treatment or prognosis. We will, however, upon written request, provide a patient with copies of his or her medical records, upon payment of the costs of photocopying.

We reserve the right upon proper notice to terminate our services to any patient who insists that we provide reports or letters, or appear in person or by phone, in connection with a patient's pursuit of legal remedies.

By signing below, the undersigned agrees to accept the services of Cumberland Orthopaedic Associates, Ltd. upon the terms and conditions set forth herein.

Policy statement concerning confidential medical information provided to patients and their attorneys, Cumberland Orthopaedic Assoc., Ltd. (copy on file at the Dickinson Law Review office) [hereinafter Cumberland Orthopaedic Associates, Ltd.].

NEUROLOGICAL SURGERY, LTD.

POLICY STATEMENT:

CONFIDENTIAL MEDICAL INFORMATION PROVIDED TO ATTORNEYS

We are committed to maintaining a high level of specialty care for our neurosurgical patients. Each year this seems to require more and more paperwork, further encroaching upon the time we have available to spend with our patients. We want to assist you in your medical needs as much as possible, but we cannot become involved in time-consuming legal work.

Accordingly, we will readily make copies of your medical records from our office available to your attorney upon receipt of his/her written request, in accordance with a current signed authorization from you. However, we will not provide depositions for your attorney or for opposing attorneys. Also, we will not respond to requests from attorneys for separate additional reports summarizing or restating the same information.

Your signature below will attest to your understanding and acceptance of the above-stated policy of Neurological Surgery, Ltd.

Policy Statement: Confidential Medical Information Provided to Attorneys, Neurological Surgery, Ltd. (copy on file at the Dickinson Law Review office).

81. Cumberland Orthopaedic Associates, Ltd., *supra* note 80.

1. The Duty to Render Full Medical Treatment Includes a Duty to Render Litigation Assistance.—Some jurisdictions hold that a treating physician has a duty to render reasonably required litigation assistance to the patient. New Jersey recently adopted this view in *Spaulding v. Hussain.*[82] In *Spaulding*, the plaintiff sustained permanent orthopedic and neurological injuries when he slipped on grease and fell into a pit at a scrap metal yard.[83] His injuries required surgery, repeated hospitalizations, and rehabilitation.[84] Plaintiff's primary treating physician was Dr. Hussain.[85] The plaintiff filed a negligence action against the scrap yard owner and sought to solicit litigation assistance from his physician.[86] Dr. Hussain agreed to testify upon advance notice.[87] The doctor was given the requisite notice, but never appeared at the trial to testify.[88] Plaintiff brought a subsequent action against Dr. Hussain on contract and tort theories.[89] The superior court affirmed the lower court's holding that Dr. Hussain was liable to the plaintiff on both contract and tort grounds.[90]

The *Spaulding* court recognized the enforceability of a treating physician's affirmative agreement to testify.[91] In addition, the court reasoned that a treating physician has an implied duty to "render reasonably required litigation assistance to his patient."[92] The court, however, declined to answer whether that assistance "unequivocally and invariably requires the physician to testify in court."[93] Rather, the court suggested that a physician, who at the start of treatment expressly refuses to testify for a patient, is not thereby relieved from supplying other assistance, such as producing medical reports or consulting with counsel.[94] A physician who does not make a disclaimer is not, according to the court, necessarily left without any choice but to testify. The *Spaulding* court would allow the physician to give

82. 229 N.J. Super. 430, 551 A.2d 1022 (N.J. Super. Ct. App. Div. 1988).
83. *Id.* at 433, 551 A.2d at 1023.
84. *Id.*
85. *Id.*
86. *Id.* at 433, 551 A.2d at 1023-24.
87. Spaudling v. Hussain, 229 N.J. Super. 430, 433, 551 A.2d 1022, 1024 (N.J. Super. Ct. App. Div. 1988).
88. *Id.*
89. *Id.* at 435, 551 A.2d at 1025-26.
90. *Id.* at 445, 551 A.2d at 1030.
91. *Id.* at 440, 551 A.2d at 1027.
92. Spaulding v. Hussain, 229 N.J. Super. 430, 440, 551 A.2d 1022, 1028 (N.J. Super. Ct. App. Div. 1988).
93. *Id.*
94. *Id.* at 440-41, 551 A.2d at 1028.

assistance by other means pursuant to the rules of civil procedure.[95]

Spaulding follows the judicial views expressed in *Alexander v. Knight*[96] and *Hammonds v. Aetna Casualty & Surety Co.*[97] At issue in these cases was whether a treating physician breached the patient-physician relationship by giving information to the patient's litigation adversary. In answering affirmatively, both courts expressed the opinion that physicians owe more than just medical care to their patients.[98] There is a duty of total care that includes the duty to "offer . . . medical testimony on behalf of [the] patient if the patient becomes involved in litigation over the injury or illness which the doctor treated."[99]

Although the *Spaulding* court did not outline the parameters of the physician's duty to assist with litigation, it stressed that a physician must not disregard the "basic obligation" of providing at least a "modicum" of assistance.[100] The opinion clearly stated that, at the very least, reasonably required litigation assistance includes medical reports, deposition testimony, or consultation with patients' attorneys.[101]

The Montana Supreme Court, when faced with a factually similar situation, rejected the *Spaulding* reasoning. In *Knight v. Johnson*,[102] the treating doctor was deposed and later informed by letter, of the plaintiff's trial date.[103] The doctor failed to appear at the trial, and plaintiff brought a negligence action against him.[104] Citing *Spaulding*, the plaintiff claimed that his doctor had a duty to appear and testify at the trial.[105]

The court refused to adopt the *Spaulding* position, reasoning that a plaintiff's interest in compelled testimony is protected by the subpoena process.[106] The court held that "no duty exists for a [treating] physician to testify at the trial of a patient, absent compulsory

95. *Id.* For instance, the physician could submit to a videotaped deposition pursuant to N.J. CT. R. 4:14-9.

96. 25 Pa. D. & C.2d 649 (1961), *aff'd*, 197 Pa. Super. 79, 177 A.2d 142 (1962).

97. 243 F. Supp. 793 (N.D. Ohio 1965).

98. Hammonds v. Aetna Casualty & Sur. Co., 243 F. Supp. 793, 799 (1965); Alexander v. Knight, 25 Pa. D & C.2d 649, 655, 177 A.2d 142, 146 (1961), *aff'd*, 197 Pa. Super. 79, 177 A.2d 142 (1962).

99. *Hammonds*, 243 F. Supp. at 799.

100. Spaulding v. Hussain, 229 N.J. Super. 430, 441, 551 A.2d 1022, 1028 (N.J. Super. Ct. App. Div. 1988).

101. *Id.*

102. 237 Mont. 230, 773 P.2d 293 (1989).

103. *Id.* at ____, 773 P.2d at 293.

104. *Id.* at ____, 773 P.2d at 294.

105. *Id.*

106. *Id.* at ____, 773 P.2d at 294.

process."[107]

Since few cases discuss a physician's duty to render litigation assistance, no clear rule has emerged. The majority of the existing cases seem to favor imposing a common law duty on doctors to render litigation assistance.

2. Interference With the Patient's Right to Full Compensation for Injuries.—Every citizen has the right to sue.[108] For every injury there is a remedy, and damages are often the compensation that the law will award.[109] When a treating physician refuses to render litigation assistance, that physician interferes with the patient's right to receive full compensation for injuries sustained.

A physician's litigation assistance usually involves expert medical testimony. There is no general policy that requires expert testimony to be a part of the evidence on subjects open to expert testimony.[110] There is an exception to this rule, however. When issues require special experience, only a person with that special experience is permitted to testify.[111] The increased complexity of medical care has made medical issues less comprehensible to the average juror. More lawyers have come to rely on the specialized knowledge of medical experts to assist with explanations to the jury.[112] Indeed, many courts require expert medical testimony for proof of causation and degree of disability.[113]

An expert witness is not a representative of a party to the litigation.[114] Nonetheless, it is in the best interests of a plaintiff to receive the support of an empathetic expert witness. The plaintiff's treating physician is usually the best witness because of the physician's familiarity with the chronology of the plaintiff's injury. A plaintiff's attorney may be forced to retain an expert if the treating physician is

107. Knight v. Johnson, 237 Mont. 230, ____, 773 P.2d 293, 295 (1989).

108. A cause of action is considered to be property protected by the due process clause of the fourteenth amendment of the United States Constitution. Logan v. Zimmerman Brush Co., 455 U.S. 422 (1982) (employee's right to Fair Employment Practice Act's adjudicatory procedures are property protected by the due process clause).

109. Scott v. Donald, 165 U.S. 58 (1897).

110. *See* 7 J. WIGMORE, EVIDENCE § 2090 (1978).

111. *Id.* Another exception is that when an action is against a physician for malpractice, evidence on that issue *must* contain expert testimony. *Id.*

112. M. KRAFT, USING EXPERTS IN CIVIL CASES 237 (2d ed. 1982).

113. *See, e.g.*, Eno v. Watkins, 229 Neb. 855, 858, 429 N.W.2d 371, 373 (1988); Barrett v. Coast Range Plywood, 294 Or. 641, 644, 661 P.2d 926, 929 (1983). *See also* Donaldson v. Maffucci, 397 Pa. 548, 555, 156 A.2d 835, 838 (1959) (expert testimony is indispensable in a medical malpractice case).

114. Franklin v. Milner, 139 N.J. Super. 385, 387, 354 A.2d 110, 111 (L. Div. 1976), *rev'd and modified on other grounds*, 150 N.J. Super. 456, 375 A.2d 1244 (App. Div. 1977).

uncooperative or hostile to the legal profession.[115]

Physicians who impose contracts that express a policy against rendering litigation assistance[116] clearly indicate that they are hostile toward the legal profession. Plaintiffs can subpoena these doctors to testify at trial or to give depositions,[117] but that is often an unwise approach. Doctors may terminate medical treatment because of legal compulsion to render litigation assistance. In addition, compelling doctors to testify often assures that any litigation assistance received will be antagonistic. Adverse testimony may jeopardize any potential recovery for the plaintiff's injury.

Lawyers can and often do go outside the community to find an acceptable medical expert witness. It is widely recognized that local physicians will rarely testify against one another in medical malpractice cases. No compelling reasons exist, however, to prevent a local doctor from testifying in a personal injury case, or a meritorious malpractice case. Doctors are paid for their time, and trial courts readily make schedule adjustments to accommodate the needs of physician witnesses. Doctors should not let animosity toward lawyers interfere with their duty to render total patient care.

As previously noted, a physician's duty to give complete patient care may include a duty to offer litigation assistance.[118] Doctors do not necessarily have to testify in court. In fact, one state considers the duty fulfilled if the doctor submits to a videotaped deposition.[119] Other states should encourage doctors to cooperate with the legal process. States could form groups of specially trained interviewers to work within the court system. These interviewers would be responsible for deposing doctors and other witnesses who are hostile toward lawyers. The interviewers may ask questions submitted by the parties' attorneys, or may be permitted to raise questions of their own. Communication with the lawyers would be limited to trial preparation and the actual trial. This approach serves to limit doctors' contact with combative attorneys. Doctors might become more willing to assist their patients in receiving compensation for injuries.

Not every patient intends to litigate; those that do bring suit may have strong cases. A doctor's refusal to cooperate with the legal process harms the patient and serves no useful purpose. Doctors can

115. *See* M. KRAFT, USING EXPERTS IN CIVIL CASES (2d ed. 1982).

116. *See supra* note 80.

117. *See, e.g.*, FED. R. CIV. P. 45(e)(1); PA. R. CIV. P. 234 (witnesses), 4018 (depositions).

118. *See supra* notes 82-107 and accompanying text.

119. *See* N.J. CT. R. 4:14-9.

release their anger over lawsuits in more constructive ways that are less harmful to the patients they ultimately affect.[120]

3. Antitrust Violations.—It is well established that health care professionals are subject to the restrictions imposed by the Sherman Antitrust Act[121] and its state counterparts.[122] In the aftermath of the United States Supreme Court's pronouncement that the "learned professions" are not immune to antitrust claims,[123] an increasing number of antitrust actions have been filed against health care professionals and professional organizations under section 1 of the Sherman Act. Frequently, allegations raised against professionals involve claims of illegal boycott activity.[124]

An antitrust violation consists of a contract, combination, or conspiracy that acts to unreasonably restrain trade and has an effect upon interstate commerce.[125] The interstate commerce requirement is met if a restraint occurs "in" or has a "substantial effect on" interstate commerce.[126] Traditionally, professional activity was considered to be localized and would not satisfy these tests. After the Supreme Court's ruling in *Goldfarb v. Virginia State Bar*,[127] the interstate commerce requirement could be fulfilled by a showing that the local professional activity was an "integral" part of transactions related to interstate commerce.[128] The requirement was further relaxed in *McLain v. Real Estate Board of New Orleans, Inc.*[129] The Supreme Court held that an effect on interstate commerce is established when the local activity challenged is shown " 'as a matter of practical economics' to have a not insubstantial effect on the interstate commerce involved."[130] In medical practice cases, the interstate

120. *See infra* notes 180-93 and accompanying text.

121. Section 1 of the Sherman Antitrust Act provides: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." 15 U.S.C. § 1 (1988).

122. State antitrust laws are usually patterned after the federal statute. *See, e.g.*, TEX. BUS. & COM. CODE ANN. § 15.05 (Vernon 1987 & Supp. 1990); ME. REV. STAT. ANN. tit. 10, § 1101 (1980 & Supp. 1989). Pennsylvania is the only state without its own antitrust laws.

123. Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

124. *See* Gilmore, *The Antitrust Implications of Boycotts by Health Professionals: Professional Ethics and the First Amendment*, 14 AM. J.L. & MED. 221 (1988).

125. *See supra* note 121.

126. Burke v. Ford, 389 U.S. 320 (1967).

127. 421 U.S. 773 (1975).

128. *Id.* at 784-85 (citing United States v. Frankfort Distilleries, 324 U.S. 293, 297 (1945)).

129. 444 U.S. 232 (1980).

130. *Id.* at 246 (quoting Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738, 745 (1976)). The impact that a defendant's professional activity has on interstate commerce is a question of fact to be decided on a case-by-case basis. Williams v. St. Joseph Hosp., 629 F.2d 448, 454 (7th Cir. 1980).

commerce nexus is demonstrated by such factors as patient origin, purchase of medical supplies and pharmaceuticals from out-of-state suppliers, and insurance payments made by out-of-state insurers (including the federal government).[131]

Concerted activity exists when two or more persons contract, combine, or conspire to promote conduct that unreasonably restrains trade. A "group boycott" is a concerted refusal to deal and violates antitrust laws.[132] Conversely, a unilateral refusal to deal does not violate the Sherman Act.[133]

The definition of a boycott is not limited to situations in which the target of the concerted refusal to deal is another competitor. A boycott of patients may constitute a refusal to deal in violation of the Sherman Act. In *Williams v. St. Joseph Hospital*,[134] a class action was filed on behalf of all persons who had filed or had the potential to file a malpractice suit against any doctor in a certain town.[135] All the doctors were allegedly engaged in a conspiracy to refuse to treat any person or family member of any person who had initiated a malpractice suit against any doctor in the area.[136] On defendants' motion for summary dismissal, the district court entered judgment for the defendants.[137] The Court of Appeals for the Seventh Circuit reversed and remanded, holding that the plaintiffs had sufficiently established a cause of action under the antitrust laws.[138] The court reasoned that the professional boycott interfered with the free market for the purchase of medical services and also restricted the freedom of doctors to provide services.[139] The remaining question on remand was whether such restrictions had the requisite impact upon interstate commerce.[140]

Physicians who require their patients to agree to terms of treatment such as those set forth by Cumberland Orthopaedic Associates[141] might be violating antitrust laws. These contracts, in effect, cause a boycott of medical consumers who are also litigants. The questions raised are whether this type of boycott (1) is the result of a

131. *See* Feminist Women's Health Center v. Mohammed, 586 F.2d 530, 539 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979).
132. Northern Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958).
133. United States v. Colgate & Co., 250 U.S. 300, 307 (1919).
134. 629 F.2d 448 (7th Cir. 1980).
135. *Id.* at 450.
136. *Id.*
137. *Id.* at 448.
138. *Id.* at 453-54.
139. Williams v. St. Joseph Hosp., 629 F.2d 448, 453 (7th Cir. 1980).
140. *Id.* at 454. There is no published decision of the case on remand.
141. *See* Cumberland Orthopaedic Assocs., Ltd., *supra* note 80.

conspiracy or combination of physicians; and (2) is an unreasonable restraint on trade that has a "not insubstantial" effect on interstate commerce.

(a) Conspiracy or combination.—The existence of a conspiracy or combination, more often than not, must be inferred from circumstantial evidence. Any evidence may be employed if it indicates that the defendants entered into an agreement to take joint action.[142] Circumstantial proof of conspiratorial action may include meetings attended by the defendants at which they had a chance to conspire, followed shortly thereafter by parallel behavior.[143] On the other hand, it is not concerted action for a defendant to set terms and conditions of service and then to act upon this unilateral announcement, even though it is logical to expect others to follow suit.[144]

In a "boycott of patients" case, plaintiff-patients must prove that the doctors reached an express agreement to refuse to deal, or must show the same result through circumstantial evidence.[145] Physicians in group practice, all the physicians in town, or entire physician organizations may be found to have conspired against litigious patients. A contract that denies litigation assistance may be the vehicle used to carry out the conspiracy. However, if one physician, frustrated by the rise in malpractice insurance costs, decides to avoid litigious patients, it is not concerted action when other doctors like the idea and conform to it.[146]

(b) Unreasonable restraint on trade.—An unreasonable restraint on trade is determined through application of either the *per se* rule or the "rule of reason" analysis.[147] Traditionally, group boycotts are illegal *per se*.[148] A plaintiff must prove only that a boycott exists; the

142. Monsanto Co. v. Spray-Rite Serv. Corp., 465 U.S. 752, 764 (1984) ("[E]vidence [to show a conspiracy must] reasonably tend . . . to prove that the [defendants] . . . 'had a conscious commitment to a common scheme designed to achieve an unlawful objective'" (quoting Edward J. Sweeney & Sons v. Texaco, 637 F.2d 105, 111 (3d Cir. 1980), *cert. denied*, 451 U.S. 911 (1981))).

143. *Id.* at 765-66.

144. *Id.* at 762-63.

145. *See supra* notes 121, 142 and accompanying text.

146. In 1986, obstetricians, neurologists, and orthopedic surgeons in Boston and Florida stopped accepting patients in protest of malpractice insurance rate increases. There were questions about antitrust violations, but no actual prosecutions were initiated. The doctors insisted that each practitioner acted individually. *See Doctors Deny Antitrust Allegations*, U.P.I. Feb. 12, 1989 (Lexis, Nexis library, Omni file); *Doctors Withhold Services in Protest on Insurance*, N.Y. Times, Dec. 10, 1986, at A25, col. 1 (city ed.).

147. *See* W. HOLMES, 1988 ANTITRUST LAW HANDBOOK § 1.04.

148. Northern Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958); Klor's, Inc. v. Broadway-Hale Stores, 359 U.S. 207, 212 (1959).

court may then presume that the defendant intended to illegally restrain trade.[149]

In cases involving group boycotts by physicians, courts often choose to apply the more flexible rule of reason standard.[150] The rule of reason allows courts to permit certain boycotts when they are not primarily motivated by anticompetitive outcomes.[151] If, for example, an alleged restraint of trade is founded upon a public service rationale or a professional ethical norm, rule of reason analysis is employed.[152] In antitrust cases, courts generally examine the purpose behind a specific agreement, the market power of the parties, the existence of a less restrictive alternative, and the agreement's procompetitive and anticompetitive effects.[153]

Additionally, in medical practice cases, defendants are granted a legal excuse for anticompetitive behavior. This excuse is termed the "patient care defense."[154] The patient care defense is applied only in cases involving disputes over scientific methods.[155] Most courts seem to believe that the rule of reason gives sufficient force to public service rationales and that the patient care defense is not necessary.[156]

The Cumberland Orthopaedic and Neurological Surgery physicians explicitly state in their patient consent forms that they are con-

149. *Northern Pac. Ry.*, 356 U.S. at 5.

150. These cases address primarily the antitrust effects of professional ethical canons and public service policy statements. *See, e.g.*, Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985); Wilk v. AMA, 719 F.2d 207 (7th Cir. 1983), *cert. denied*, 467 U.S. 1210 (1984). *See also* Gilmore, *supra*, note 124. The same basic antitrust rules, however, apply to the boycott-of-patients cases. *See, e.g.*, Williams v. St. Joseph Hosp., 629 F.2d 448 (7th Cir. 1980).

151. W. HOLMES, 1988 ANTITRUST LAW HANDBOOK § 1.09[1].

152. *See* National Soc'y of Prof. Eng'rs v. United States, 435 U.S. 679 (1978) (professional organization promulgated ethical canons proscribing competitive bidding among its membership to minimize the risk that competition would produce inferior engineering work, endangering the public safety); *Wilk*, 719 F.2d at 207 (AMA took measures to persuade traditional health care providers that cooperation or association with chiropractors would be unethical).

153. *See generally* 7 P. AREEDA, ANTITRUST LAW, ¶¶ 1500-11 (1978 & Supp. 1989). The rule of reason requires plaintiffs to show actual harm to competition. *National Soc'y of Prof. Eng'rs*, 435 U.S. at 691. Defendants are allowed to present countervailing procompetitive aspects of their boycott. *Id.*

154. *Wilk*, 719 F.2d at 228-29. The patient care defense is satisfied if: (1) the defendant genuinely entertained a concern for the care of patients; (2) that concern was objectively reasonable; (3) concern for patients was the dominant motivating factor for the defendant's actions; and (4) the concern for patients could not have been satisfied in a manner less restrictive of competition. *Id.* at 227.

155. *See* FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986); Koefoot v. American College of Surgeons, 652 F. Supp. 882 (N.D. Ill. 1986) (Supp. Memo. Opinion & Order 1987).

156. *See* Gilmore, *supra* note 124, at 234-38.

cerned with providing quality care for their patients.[157] Patient care, however, does not seem to be the primary motive behind their contracts. Rather, the contracts appear to function solely for the doctors' convenience. The contracts have undertones of disdain for persons who try to seek compensation for their injuries. They effectively discourage requests for treatment from patients who may want to litigate a perfectly legitimate claim. If challenged in court, these contracts and the resulting restraint of trade would probably be tested under the *per se* rule.

With these contracts in effect, patients who need litigation assistance are limited to choosing physicians who will provide this service in addition to medical treatment. Some patients may be denied any choice at all.[158] If the physicians truly place patient care first, they would agree to provide litigation assistance as part of the total package of care.

(c) Effect on interstate commerce.—The amount of interstate commerce affected by a defendant's activity is a fundamental consideration when the concerted activity challenged is technically intrastate in character. The "substantial effects" test requires that the amount of interstate commerce affected must be more than *de minimis*,[159] but need not be enormous.[160] Private physicians' antilitigation contracts, which essentially bar litigious patients from treatment, may have a substantial effect on interstate commerce. Factors to consider in such an analysis would be: the number of doctors utilizing the contracts, the number of patients actually denied treatment, and the corresponding effect upon the physicians' interstate purchases and business with out-of-state patients.

Antitrust regulation clearly reaches physician boycott activity. Nevertheless, antitrust litigation will probably not provide litigant-patients with greater access to medical care. Other regulations are more likely to succeed.[161]

4. Unconscionability of Contract.—A variety of health care

157. *See supra* note 80.

158. Research for this Comment did not reveal whether other physician groups in Harrisburg, Pa., or physicians elsewhere in the nation, are employing similar contracts. It appears that the various national medical organizations frown upon such contracts. *See infra* note 174.

159. McLain v. Real Estate Bd. of New Orleans, Inc., 444 U.S. 232, 246 (1980).

160. Feminist Women's Health Ctr. v. Mohammed, 586 F.2d 530, 541 (5th Cir. 1978) (cessation of abortion clinic's out-of-state purchases and out-of-state business totaling $16,000 would amount to a substantial impact on interstate commerce).

161. *See infra* notes 189-226 and accompanying text.

contracts have been examined under the judicial microscope. For example, some contracts purport to limit the health care provider's tort liability.[162] Courts have traditionally refused to enforce these exculpatory provisions within health care contracts, holding them to be against public policy.[163] Courts are more apt to enforce contracts calling for fairer alternative methods of resolving malpractice claims, such as arbitration.[164] These contracts do not bear the stigma of a public policy violation because they still provide patients with an opportunity to seek compensation for injury.[165]

A number of commentators support the use of contract, rather than tort, as the source of a patient's entitlement to both medical treatment and legal assistance in a malpractice suit.[166] Arbitration clauses, for example, are designed to modify patients' tort rights so as to protect physicians from harsh malpractice liability verdicts.[167] Contract provisions that attempt to waive a physician's duty to offer litigation assistance have little to do with shielding physicians from medical malpractice lawsuits. Rather, these "antilitigation" contracts resemble the unconscionable exculpatory clauses.

The unconscionability of a contract rests upon the disparity of the parties' bargaining power and the use of standardized contracts of adhesion.[168] In cases of adhesion contracts, one party has superior bargaining power and often offers the contract on a "take it or leave it" basis.[169] The weaker party does not have an opportunity to nego-

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162. *See* Ginsburg, Kahn, Thornhill & Gambardella, *Contractual Revisions to Medical Malpractice Liability*, 49 LAW & CONTEMP. PROBS. 253 (1986).

163. The seminal case holding an exculpatory clause in a medical care contract to be invalid is Tunkl v. Regents of Univ. Calif., 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963). *See also* Emory Univ. v. Porubiansky, 248 Ga. 391, 282 S.E.2d 903 (1981) (public policy will not allow a physician to contractually release himself from the legal and ethical duty to exercise reasonable care).

164. *See generally* Annotation, *Arbitration of Medical Malpractice Claims*, 84 A.L.R. 3D 375 (1978).

165. Over two-thirds of the states have general statutes that authorize agreements to arbitrate. A minority of states have statutes that specifically authorize arbitration agreements relating to medical malpractice claims. *See generally* Henderson, *Agreements Changing the Forum for Resolving Malpractice Claims*, 49 LAW & CONTEMP. PROBS. 243 (1986). The validity of arbitration agreements depends upon the contract principles regarding fair dealing. *See* Obstetrics & Gynecologists v. Pepper, 101 Nev. 105, 693 P.2d 1259 (1985) (clinic offered arbitration agreement on a take-it-or-leave-it basis, resulting in finding of an adhesion contract, which was held unenforceable in absence of evidence of plaintiff's knowing assent).

166. *See Symposium: Medical Malpractice: Can the Private Sector Find Relief?*, 49 LAW & CONTEMP. PROBS. 1 (1986). The symposium articles outline the views for and against the use of contracts in medical care.

167. Ginsburg, Kahn, Thornhill & Gambardella, *supra* note 162, at 253-55.

168. *See* Tunkl v. Regents of Univ. Calif., 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963).

169. Madden v. Kaiser Found. Hosps., 17 Cal. 3d 699, 711, 552 P.2d 1178, 1185, 131 Cal. Rptr. 882, 889 (1976); Morris v. Metriyakool, 418 Mich. 423, 440, 344 N.W.2d 736, 742

tiate and may not have the freedom to look elsewhere for a more favorable contract.[170]

The general rule that parties to a contract are bound by its terms becomes ineffective when the contract is one of adhesion,[171] although there is an exception to this exception.[172] Contracts that purport to disclaim a private physician's duty to render reasonable litigation assistance may qualify as adhesion contracts because: (1) they are offered on a take it or leave it basis; (2) individual patients are not given an opportunity to negotiate for more favorable terms; (3) with the exception of metropolitan areas, patients do not have the opportunity to look elsewhere for a more favorable contract;[173] and (4) these contracts serve to limit the obligations of physicians. If challenged, the validity of antilitigation contracts would depend upon the circumstances surrounding the agreement. Physicians must print the contracts on a separate sheet of paper and must be sure they are legible. Physicians should read over the contract with the patient and answer all questions before the patient signs it.

If courts enforce antilitigation contracts, patients may suffer a double loss: termination from treatment if the patient insists upon soliciting the physician's litigation assistance, and the possibility of an insufficient damage award as a result of no litigation assistance. Neither result can be said to fulfill the reasonable expectations of the patient entering a medical treatment contract.

5. Violations of Medical Ethics Codes.—Doctors have, in various medical ethics codes, pledged a duty to cooperate with the legal profession for the welfare of their patients.[174] Ethics codes are not

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(1984).

170. *Madden*, 17 Cal. 3d at 711, 552 P.2d at 1185-86, 131 Cal. Rptr. at 889-90.

171. *Id.* at 711, 552 P.2d at 1185, 131 Cal. Rptr. at 889.

172. Courts will enforce provisions in adhesion contracts that limit the duties or liabilities of the stronger party when the limiting clause is "conspicuous, plain, and clear and [does] not operate to defeat the reasonable expectations of the parties." *Id.* (quoting Steven v. Fidelity & Casualty Co., 58 Cal. 2d 862, 377 P.2d 284, 27 Cal. Rptr. 569 (1962)).

173. Some patients may have to travel up to 100 miles to find a suitable doctor. *See Delivery Practice Faltering*, *supra* note 39, at 37.

174. Some examples of these ethical code provisions are:

> III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
>
> IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

AMA PRINCIPLES OF MEDICAL ETHICS, Principles III, IV (1980).

> The neurological surgeon shall cooperate with members of the legal profession in order that justice with mercy and compassion shall prevail.

AMERICAN ASSOC. OF NEUROLOGICAL SURGEONS, CODE OF ETHICS § V ¶ C.

laws, but rather are "standards of conduct which define the essentials of honorable behavior for the physician."[175] Nevertheless, policy statements regarding standards of care have occasionally been treated as evidence of a legal standard of care or practice.[176] An ethics code promulgated by an influential organization, such as the American Medical Association, could be offered in court as representative of a legal standard of practice. Contracts that waive litigation assistance should be held to violate that legal standard.

IV. Regulating the Physician-Patient Relationship: Everyone's Responsibility

Medical practice is subject to heavy regulation. Almost every aspect of the system is controlled by federal, state, and local government rules. Practitioners are also subject to self-regulation.[177]

One aspect of private medical practice that has remained essentially free from regulation is the physician's right to choose whom to treat.[178] Some health care commentators would eliminate this right in favor of a public utility approach to health care regulation in order to assure access to health care for everyone.[179] The public utility approach is problematic, however, because it may harm patients rather than help them.

Unlike public utilities, medical treatment consists of a complex array of specialized services. Medical practice requires a high level

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Personal Conduct

The physician-patient relationship is the central focus for all ethical concerns. The orthopaedic surgeon is expected to provide competent and compassionate care . . . and maintain the patient's best interests as paramount in all professional conduct.

. . .

The orthopaedic surgeon should observe all laws, uphold the dignity and honor of the profession, and accept its self-imposed discipline.

AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS, CODE OF ETHICS, Personal Conduct (1988).

175. AMA, PRINCIPLES OF MEDICAL ETHICS Preamble (1980).

176. *See* Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965) (hospital regulations, standards, and bylaws provide evidence of a custom of care).

177. The statutory medical licensing schemes of the states provide the mechanisms for self-regulation by the medical profession. Professional organizations and their ethics codes and principles are another source of physician regulation. *See* AMA, PRINCIPLES OF MEDICAL ETHICS (1980).

178. Doctors vigorously exercise the right to turn patients away. *See supra* notes 21-64. Recently, physicians have also refused to treat AIDS patients. The AIDS epidemic prompted the AMA to release a policy statement about the duty to treat persons with AIDS: "A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is seropositive [for AIDS]." AMA Council on Ethical and Judicial Affairs, *Ethical Issues Involved in the Growing AIDS Crisis*, 259 J. A.M.A. 1360, 1360 (1988).

179. *See, e.g.*, D. RUTSTEIN, BLUEPRINT FOR MEDICAL CARE (1974).

of competency, which private competition tends to foster. A national health care program would eliminate the fee-for-service system, in turn eliminating freedom of choice and competition. Eliminating competition has the potential to reduce physician competency.

Physicians should not lose the right to choose whom to serve. At the same time, doctors must not continue to arbitrarily deny medical services to persons who are associated with a lawsuit. Clearly, the underlying problem concerns the resentment, hurt, and humiliation doctors feel about medical malpractice suits. These feelings are pervasive, whether or not a doctor has actually been sued, because every doctor is affected by the increase in malpractice insurance costs that is often attributed to malpractice lawsuits.

The medical profession has every right to be worried about malpractice lawsuits. It is unethical, however, for doctors to take out their personal anger on innocent patients. In order to protect the doctor-patient relationship, society must go to the core of the problem. Physicians, lawyers, states, and consumers can, and should, work together toward finding solutions to this common problem.

A. Physicians

Many physicians file countersuits in response to being sued for malpractice.[180] When it became clear that countersuits were largely unsuccessful, physicians turned to other retaliatory devices. The antilitigation contract discussed in this Comment is one such device.

Physicians who impose antilitigation contracts on their patients must remember that not every lawsuit is frivolous. Errors in the treatment of patients do occur, some of them with severe consequences. Physicians may try to avoid litigation and litigious patients. Avoidance is legally permissible, but ethically inexcusable. If these patients are continually rejected, eventually the law will protect them.

Instead, doctors must increase interprofessional communication with lawyers. Some commentators suggest that the greatest source of conflict between doctors and lawyers is the difference in the way the two professions reason and solve problems.[181] To help resolve the conflict, state and local bar and medical associations have estab-

180. The legal theories of countersuits include negligence, abuse of process, and malicious prosecution. *See* Friedman v. Dozorc, 412 Mich. 1, 312 N.W.2d 585 (1981) (a comprehensive opinion on the validity of countersuits).

181. *See* Gibson & Schwartz, *Physicians and Lawyers: Science, Art, and Conflict*, 6 AM. J.L. & MED. 173 (1981).

lished interdisciplinary committees.[182] The purpose of these committees is to foster understanding and cooperation among the professions in order to better serve clients and patients.[183] Some of these associations have set forth guidelines for interprofessional relationships,[184] which would be instructive to newly organized associations.

Once an interprofessional association is established, the association should organize continuing education seminars.[185] These seminars could be offered monthly to present current events affecting both professions. Attendance at the seminars should be a mandatory requirement for membership in each professional organization.

To reach the goal of placing the patient's interest and welfare first, physicians must strive to better communicate with their patients. Fortunately, medical schools are teaching their students to place more emphasis on the doctor-patient relationship.[186]

Practicing physicians can improve communication with their patients by better understanding patient attitudes toward doctors. Studies indicate that patients rely upon certain misconceptions about medical malpractice.[187] Doctors, too, have misconceptions about pa-

182. *See, e.g., infra* notes 193-95 and accompanying text.

183. *Guidelines on Attorney and Physician Relationships*, 73 ILL. B.J. 486-88 (1985) (introductory letter to members).

184. *See, e.g., Guidelines on Attorney and Physician Relationships*, 73 ILL. B.J. 486-88 (1985). The Illinois Bar Association and Illinois Medical Society recognize that the duty of a physician includes rendering litigation assistance.

The Kentucky interprofessional association also asserts that a physician has an ethical obligation to give depositions, written medical reports, and testimony on behalf of his patient. *See Interprofessional Code—Kentucky Medical Association and Kentucky Bar Association*, 87 J. KY. MED. ASSOC. 39-44 (1989). Both codes are comprehensive and should be considered by professional organizations currently without interprofessional standards.

185. Ohio doctors and lawyers established a two-part educational program. First, doctors give lawyers a course in functional anatomy. Then, the lawyers teach a basic course covering the mechanics of personal injury and medical malpractice lawsuits. *See* Appelson, *Doctors and Lawyers Learning to Live Together*, B. LEADER, May-June 1982, at 23.

186. The School of Medicine at the University of Missouri at Kansas City and Harvard Medical School have both incorporated humanistic courses into their curricula. *See* Gibbs, *supra* note 1, at 53.

187. These myths are:

> There is a great deal of malpractice in today's health care system.
>
> In fact, most clinicians provide services [that are] . . . above acceptable standards in their respective fields.
>
> Negligence is found in most malpractice claims.
>
> In fact, the majority of malpractice claims are resolved in favor of [the defendant] . . . .
>
> Most patients . . . sue because they have evidence that the doctor was negligent.
>
> [In fact,] [m]ost malpractice insurance companies conclude that anger and surprise by patients over unanticipated clinical outcomes trigger a large percentage of malpractice lawsuits.
>
> Most malpractice suits are linked to incompetent physicians.
>
> [In fact,] the majority of . . . claims are made against qualified [physi-

tient motivations for bringing malpractice suits.[188] Most misconceptions can be eliminated through education. In addition to giving individual patients a thorough explanation of procedures and risks,[189] physicians should provide consumer education seminars about their specialties to the community. Doctors should also prepare public service announcements for local television and radio stations that encourage patients to ask questions of their doctors. A small amount of time donated by doctors to educate their patients will go a long way toward preventing future lawsuits and will help restore patient trust in the medical profession.

In addition to improving physician-lawyer and physician-patient relationships, doctors should continue to seek relief from insurance cost increases. Physicians might be more willing to offer assistance to litigant-patients if medical malpractice insurance premiums decrease. Although everyone would benefit from an abatement, only doctors seem to aggressively seek solutions.[190]

Insurance rates have, in fact, dropped for the first time in over a decade.[191] In 1989, some medical malpractice insurers either decreased their malpractice insurance premiums or continued the premiums at flat rates.[192] Insurers attribute the rate abatement to a drop in the number of claims filed and a decrease in extraordinarily high jury awards.[193] If this is a harbinger of things to come, doctors

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cians] . . . who receive [outstanding] peer review reports.
Nelson, *Heed Consumers On Malpractice To Avoid Suits*, HOSPS., Sept. 20, 1987, at 64.

188. Doctors believe that money is the motivating factor for bringing a malpractice suit. *Id.* The current opinion among observers is that plaintiffs sue because they are angry at physicians for not communicating. Patients may also sue because they have been treated with indifference, lack of sincerity, or disrespect. *Id. See also* Gibbs, *supra* note 1, at 52 (statement of consumer advocate Michael Rooney) ("It's when [the patients] feel they've been hurt or betrayed that they sue.").

189. This explanation is more commonly known as informed consent. *See generally* Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407 (1980); Meisel & Roth, *Toward An Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 ARIZ. L. REV. 265 (1983); J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

190. Some proposals thinly disguise doctors' contempt for lawyers. On January 13, 1988, the AMA announced a proposal to change the way malpractice claims are resolved. *See* Holthaus, *Take Malpractice Cases Out of the Courts: AMA*, HOSPS., Feb. 5, 1988, at 58. The plan would replace the present jury system with an administrative system run by state medical boards or new state agencies. *Id.* Lawyers' roles would be minimal or nonexistent. Doctors claim that the plan would reduce the practice of defensive medicine and would keep doctors from limiting their practices. *Id.* The problem with this proposal is that it places the resolution of claims process in the control of doctors instead of lawyers without any safeguards for consumers.

Physicians are also trying to eliminate incompetent colleagues. Physician-owned insurance companies have successfully exposed negligent doctors. *See supra* note 47.

191. *See* Gastel, *supra* note 3.

192. *See id.*

193. *See id.*

may cease restricting their practices.

A final suggestion to help doctors improve the physician-patient relationship focuses upon ethical conduct. Professional medical organizations should consider putting more force behind their ethical codes. There is an inherent conflict between individual professionals and the requests from prominent medical organizations that physicians live up to their ethical obligations. Organizations might enforce their standards by requiring compliance with them, rather than merely requesting compliance. Physicians who fail to uphold the standards should be sanctioned. Sanctions can include a publication of violations, a report to state medical boards, and a report to hospital peer review boards. These sanctions would apply to doctors who employ antilitigation contracts because the contracts allow doctors to breach their ethical duty to cooperate with the legal process[194] on behalf of their patients.

B. Lawyers

Lawyers, too, can help ameliorate the tension in doctor-patient relations. Although doctors struggle to contain malpractice insurance costs, lawyers question whether a liability crisis ever existed.[195] Lawyers cannot ignore the fact that high insurance premiums are affecting medical practice to the detriment of society. Furthermore, lawyers cannot ignore the fact that doctors blame lawyers for the crisis.[196] Whether responsible or not, lawyers must work with doctors to resolve the problem. Both professions must approach the matter with their patient-clients' interests in mind.[197]

Lawyers may believe that they can best serve their clients by helping them challenge physician conduct that interferes with traditional patient rights. Antilitigation contracts may violate patient rights in a number of ways.[198] Lawyers could decide to engage in litigation with doctors who enforce such contracts. Attorneys should not, however, be hasty to initiate such suits. One successful antitrust suit benefits one class of patients, but could harm patients as a whole. If doctors are forced to treat all patients, there is a possibility

194. *See supra* note 174.

195. *See* Saks, *supra* note 71, at 77-79. *See also* Reske, *Was There a Liability Crisis?*, A.B.A. J., Jan. 1989, at 46 (report about antitrust suits filed against four insurance companies charging conspiracy to limit availability of commercial insurance and to cut other costs, such as legal expenses to defend against claims).

196. *See supra* notes 15-16 and accompanying text.

197. Lawyers should also recognize that their own health interests are at stake.

198. *See supra* notes 82-173 and accompanying text.

that treatment will be mediocre at best. If doctors are forced to render litigation assistance, in all likelihood the assistance will be ineffective. Since some malpractice insurance rates are dropping,[199] doctors may become more relaxed with lawyers and litigants. For the time being, attorneys should defer initiating such lawsuits.

Instead, lawyers should join doctors in establishing interprofessional committees to improve professional relations. Both professions help society in a fiduciary capacity by working to serve the public. Society is best served when the two professions interact amicably.

It is often said that lawyers are held to the same level of esteem as used-car salesmen. Perhaps this view has evolved because attorney advertisements sound much like used car advertisements.[200] Through their advertisements, many plaintiffs' attorneys perpetuate the litigious attitude that doctors and others loathe. Instead, attorneys and clients should first explore possible alternatives to the litigation process.[201] Lawyers could also attempt to dispel the belief that a lawsuit is the only way to receive compensation for injury by presenting community education seminars in all areas of the law. With respect to medical malpractice, lawyers could explain available alternatives to suing and how the alternatives compare to the legal process.

Finally, attorneys can establish amiable relations with doctors by allowing only experienced or specially trained lawyers to litigate medical malpractice cases. These attorneys would have extensive knowledge about medical practice and about the particular injury involved in the suit. At the same time, attorneys must accept the responsibility of weeding out incompetent and unethical colleagues.[202]

C. *States*

States have a special interest in regulating health care. Protection of public health is one of the duties devolving on states in the exercise of their inherent police powers.[203] To protect their citizens, states impose many restrictions on the way physicians practice

199. *See infra* notes 202-04 and accompanying text.

200. Lawyer advertising is controlled by rules of professional conduct. *See* MODEL RULES OF PROFESSIONAL CONDUCT Rule 7.1 (1987); MODEL RULES OF PROFESSIONAL CONDUCT Rule 7.2 (1990); MODEL CODE OF PROFESSIONAL RESPONSIBILITY DR 2-101 (1981).

201. *See supra* notes 164-66.

202. A lawyer's ethical duty to expose incompetent colleagues is governed by rules of professional conduct. *See* MODEL RULES OF PROFESSIONAL CONDUCT Rule 8.3 (1987); MODEL CODE OF PROFESSIONAL RESPONSIBILITY DR 1-103 (1981).

203. Dent v. West Va., 129 U.S. 114 (1889).

medicine.[204] These restrictions are generally called malpractice laws.

In the 1970s, states responded to the malpractice insurance crisis with legislative reforms of malpractice law.[205] At that time, physicians were concerned about the availability and affordability of medical liability insurance.[206] The reforms helped, but in the early 1980s, a new crisis arose. States responded again with new legislative reforms.[207]

Now, states are faced with a crisis surrounding doctor-patient-lawyer relationships.[208] States should not try to control a physician's freedom of patient choice, but state legislatures and courts should implement new reforms to malpractice law. These additional reforms may help to reduce the number of malpractice suits initiated and the number of high jury awards received. In turn, doctors may become less angry and more willing to communicate with patients on a congenial basis.

First, state courts should authorize the board of bar examiners to issue a license for medical malpractice specialization. Only lawyers with a license to specialize in malpractice cases may try them. Second, all states should follow those states that have adopted rules similar to Rule 11 of the Federal Rules of Civil Procedure. These

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204. States regulate physicians through statutory and common law. An enumeration of the myriad state statutes controlling physician conduct is beyond the scope of this Comment. For a summary of state statutes focusing on grounds for physician discipline, see *Statutes on Medical Disciplinary Boards*, 14 STATE HEALTH LEGIS. REP. 14 (Aug. 1986).

State medical boards are also subject to some federal controls. In early 1990, a National Practitioner Data Bank will begin operation. The data bank is authorized under the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-37 (Supp. V 1987). *See* Gastel, *supra* note 3. The data bank will maintain information on physicians and other health care providers that have been convicted of medical malpractice, or that have been disciplined by state boards, peer review committees, or professional societies. *Id.* Malpractice payments arising from claims and license revocation, suspension, or other disciplinary action must be reported to the data bank within 30 days. *Id.* Disciplinary actions by hospitals or professional societies must be reported in 15 days. *Id.* Hospitals must request information from the data bank on physicians that are applying for staff privileges, and every two years must request information on those physicians with privileges. *Id.* The goal of the data bank is to track physicians who have practiced negligently in one state and then moved to another state to practice. *Id.*

205. *See generally* Posner, *Trends in Medical Malpractice Insurance, 1970-1985*, 49 LAW & CONTEMP. PROBS. 37 (Spring 1986).

206. *Id.*

207. Every state except West Virginia has passed tort reform legislation. For an evaluation of the success or failure of each reform measure, see P. DANZON, THE EFFECTS OF TORT REFORM ON THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS: A SUMMARY OF RESEARCH RESULTS (1986).

Much of tort reform has been gutted by constitutional challenges and further judicial expansion of liability by the courts. For example, courts in seven states (Idaho, Illinois, New Hampshire, North Dakota, Ohio, Texas, and Washington) hold that statutory limits on noneconomic damages are unconstitutional. *See* Gastel, *supra* note 3.

208. *See generally* Gibbs, *supra* note 1.

rules allow an award of costs against attorneys who file frivolous malpractice actions.[209] Third, states should test the merit of malpractice suits through pretrial screening panels.[210] The effects of screening panels vary from state to state.[211] Those states with ineffective programs should work to revise them.

In addition, states should adopt a *Spaulding* approach[212] to create a common law duty requiring physicians to render litigation assistance on behalf of patients. Alternatively, states should codify the recognized duty to render litigation assistance.[213] Codification of the duty does not interfere with a doctor's right to choose his patients; it simply states positive law enforcing a doctor's ethical duty to provide total patient care.

To protect health care consumers, state medical boards should enforce professional ethics codes. Some states include disciplinary measures in their medical licensing statutes for violations of medical ethics codes. For example, Ohio considers that a violation of any provision of a national code of medical ethics is grounds for revocation, suspension, or refusal to grant a medical license.[214] Most national medical ethics codes request that doctors cooperate with the legal process.[215] Doctors may be deterred from refusing to participate in the legal process if they know that patients or lawyers could report an incident of refusal to the state medical board and that the board will take disciplinary action.

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209. *See, e.g.*, N.Y. CIV. PRAC. L. & R. 8303-a (McKinney Supp. 1990).

210. Pretrial screening panels typically consist of a practicing or retired judge, a physician, and a lawyer. *See, e.g.*, N.Y. JUD. LAW § 148-a (McKinney 1983 & Supp. 1990). The panel conducts hearings on malpractice cases and issues recommendations with regard to liability. *See id.* If a cause of action proves to be valid, screening panels have the authority to try to resolve the dispute. *Id.* Otherwise, a panel recommendation is submitted as evidence in any subsequent trial. *Id. See also* Gionne v. Abrams, 793 F.2d 74, 78 (2d Cir. 1986) (court, applying the New York statute, held that panel's recommendation is to be submitted to the jury like any other expert opinion). Most screening panel legislation has endured constitutional challenges. *See, e.g.*, Colton v. Riccobono, 67 N.Y.2d 571, 496 N.E.2d 670, 505 N.Y.S.2d 581 (1986); McLean v. Hunter, 486 So. 2d 816 (La. App.), *rev'd on other grounds*, 495 So. 2d 1298 (La. 1986); Perna v. Pirozzi, 92 N.J. 446, 457 A.2d 431 (1983). *But see* Aldana v. Holub, 381 So. 2d 231 (Fla. 1980) (the actual effect and operation of the statute rendered it unconstitutional).

211. *See* GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: NO AGREEMENT ON THE PROBLEMS OR SOLUTIONS 135-36 (1986).

212. *See supra* notes 87-106 and accompanying text.

213. *See supra* notes 86-114 and accompanying text.

214. OHIO REV. CODE ANN. § 4731.22(B)(14) (Baldwin 1988). *See also* PA. STAT. ANN. tit. 63, § 422.4 (Purdon Supp. 1989); UTAH CODE ANN. §§ 58-12-35, 58-12-36 (1986 & Supp. 1989); VA. CODE ANN. §§ 54.1-2914, 54.1-2915 (1988 & Supp. 1989) (statutes with provisions similar to Ohio's).

215. *See supra* note 174.

D. Consumers

Consumers have an obvious interest in improving physician-patient relationships. A consumer's contribution to improving the relationship involves, of course, education. Although the legal duty to inform is imposed on doctors, consumers have a personal responsibility to become informed about issues that affect their health and well-being.

Consumers can stay apprised of issues by forming grass roots organizations. Doctors, lawyers, judges, and state representatives should be invited to organization meetings to speak individually about medical malpractice and proposed solutions to the problem. In addition, communities should hold roundtable discussions. The purpose of a roundtable would be to allow all interested parties to air their views about medical malpractice and the doctor-patient relationship. Consumers and professionals can then form a task force to work on the relationships at the community level.[216] At all times, consumers should ask questions of anyone who has the power to affect public health and well-being.

V. Conclusion

The traditional physician-patient relationship is no longer one of trust and confidence. The specter of a potential lawsuit has caused doctors to become more cautious and suspicious of patient motives. Doctors have distanced themselves from patients, and patients, in turn, have become more distrustful of doctors. This vicious cycle creates only more conflict between doctors and patients.

Additionally, doctors are angry with lawyers about malpractice suits. To take revenge upon lawyers, doctors refuse to cooperate with the legal process. Although a doctor's litigation assistance could benefit a patient, some doctors will not render assistance because it would help benefit the patient's lawyer as well.

Patients must be protected from physician retaliation. The public interest in health and well-being requires that physicians, lawyers, states, and consumers join in an effort to improve physician-patient and physician-lawyer relationships. Doctors, lawyers, and patients must try to communicate more openly and honestly with each other. States should impose a duty upon doctors to render litigation assis-

216. Admittedly, this type of organization will probably function best in smaller communities. Citizens in smaller communities seem to have a stronger desire to cooperate with each other.

tance on behalf of a patient as part of total patient care. Professional medical organizations should enforce their ethics codes and discipline doctors that violate code provisions.

A physician should not lose the freedom to choose whom to serve. However, doctors must remember that, as fiduciaries, they have a moral and ethical obligation to provide services to whomever they are able to treat. Ethical standards of behavior are often more stringent than legal standards. Ethics-based medical care, rather than contract-based care, encourages commitment to serve those who need to be served, despite potential risks.

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