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Medical Products and Services Liability: Public Policy Requires Legislative Innovation and Judicial Restraint

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NOTE

MEDICAL PRODUCTS AND SERVICES LIABILITY: PUBLIC POLICY REQUIRES LEGISLATIVE INNOVATION AND JUDICIAL RESTRAINT

INTRODUCTION

Reflecting our societal awareness of consumer rights, courts and legislatures have expanded general tort liability theories to cover an increasing number of patient injuries. Recognizing this trend, the specific purposes of this note are threefold: First, to identify as doctrinally analogous the expansion of both medical products and medical services liability; second, to consider some of the currently significant problems related to the expansion of medical services liability; and, third, since public needs are immediate, to outline current approaches to the problem and to suggest that both courts and legislatures utilize the successful product liability contractile doctrines and restrictive legislative formulae. Such an approach will help to ensure a more rational, harmonious, and realistic treatment of medical services liability.

General tort liability may be based upon an intentional act or negligence, or it may be based upon "strict" liability, a liability without fault.[1] Whether a personal injury suit is based upon *nonnegligent* strict liability for medical products or upon *negligence* for medical services, the injured person may be placed at a disadvantage by a statute of limitations; he may not know of the injury and, therefore, may not be able to act within the pertinent statutory time limit.[2] In personal injury cases several points of time may be relevant: The time of the causative act, the time of the injury itself, the time when the injured party first knows of his injury, and the time when the injured party first knows what has caused his injury.[3] Since statutes of limitations normally begin to run when a cause of action accrues, the time may expire before the person knows that he has been injured. In

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[1] W. PROSSER, THE LAW OF TORTS § 6 (4th ed. 1971) [hereinafter cited as PROSSER].

[2] *Id.* § 30.

[3] *See* Note, *Torts—Statute of Limitations in Medical Malpractice Cases—Justice Sought and Almost Attained*, 21 DE PAUL L. REV. 234 (1971); 3 ST. MARY'S L.J. 111 (1971).

order to mitigate this harsh result, judges[4] and legislators[5] have expanded doctrines such as fraudulent concealment and the discovery rule.

I. Doctrinal Expansion of Medical Products and Medical Services Liability

A. *Fraudulent Concealment and the Discovery Rule*

Under the fraudulent concealment doctrine, when a potential defendant knowingly conceals his negligent act so that an injured party is delayed from bringing an action, the statute of limitations does not commence running until the plaintiff discovers, or reasonably could have discovered, his cause of action.[6] This doctrine would be applicable where a plaintiff discovers an injury but is reassured by the physician that nothing is wrong.[7]

Under the more general discovery rule, fraud and concealment are not necessary factors; the statute of limitations does not begin to run *until* the plaintiff has discovered, or reasonably should have discovered, his injury.[8] Where both courts and legislatures have attempted to balance the equities of the parties, the multifaceted problems with historically disfavored stale claims[9] have been arguably outweighed by the inherent inequities of lim-

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[4] Owens v. Brochner, 172 Colo. 525, 474 P.2d 603 (1970) (where misdiagnosis resulted in unnecessary surgery but there was no concealment, the court adopted the discovery rule); Flanagan v. Mount Eden Gen. Hosp., 24 N.Y.2d 427, 301 N.Y.S.2d 23, 248 N.E.2d 871 (1969) (court adopted the discovery rule for foreign objects); Acker v. Sorensen, 183 Neb. 866, 165 N.W.2d 74 (1969) (where a physician continuously made affirmative representations as to the cure of a cancerous condition, the court applied the discovery rule).

[5] Cal. Code of Civ. Pro. § 340.5 (West 1954) (establishes the fraudulent concealment doctrine and the discovery rule for actions against health care providers); Colo. Rev. Stat. Ann. § 13-80-105 (1973). The Colorado legislature specifically clarified the statutory limitation periods for medical malpractice claims by revising the statute to omit the word "accrue" and substituting the more expansive "discovered or in the exercise of reasonable diligence and concern should have discovered . . . his injuries and the negligence or breach of contract . . . ." Ch. 232, § 1, [1971] Colo. Sess. Laws 952. For examples of the traditional use of the word "accrue" in statutes of limitations, see Ga. Code Ann. § 3-1004 (1975), Kan. Stat. Ann. § 60-510 (1964), and Me. Rev. Stat. Ann. tit. 14, § 753 (1965).

[6] *See* Note, *Torts—Medical Malpractice—Statute of Limitations is Tolled When the Plaintiff Produces Prima Facie Evidence to Raise Fraudulent Concealment as a Material Issue of Fact*, 5 Tex. Tech. L. Rev. 209, 214-15 n.46 (1973).

[7] *See* Owens v. Brochner, 172 Colo. 525, 532, 474 P.2d 603, 607 (1970).

[8] *Id.*

[9] Comment, *Choice of Law: Statutes of Limitation in the Multistate Products Liability Case*, 48 Tul. L. Rev. 1130 (1974).

iting an injured person's right to sue upon first discovery of his injury.[10]

B. *Related Rules and Doctrines*

The surgical exception doctrine is closely related to the more general discovery rule, but it is limited to those cases where a foreign object has been left in a patient's body during surgery.[11] Also related to the discovery rule is the continuing treatment doctrine. Under this doctrine the statute of limitations does not begin to run from the time of the alleged malpractice act itself; so long as the potential defendant continues treating the person, the malpractice is also deemed to continue, and the statute begins to run only when this continuing treatment has terminated.[12]

The informed consent doctrine is based upon the physician's duty to sufficiently inform a patient of the risks inherent in a proposed treatment or procedure.[13] Among the factors to be considered in each case are the following: The likelihood and seriousness of possible bad results; the alternatives that are available; the necessity or urgency of treatment; and the individual patient's mental capacity and emotional maturity.[14] A physician's duty to inform involves a professional medical judgment in each individual case; the proper standards for disclosure in each case are based upon expert medical testimony as to what a reasonably prudent physician would have told that patient.[15]

Under the general tort evidentiary rule of res ipsa loquitur, when expert medical testimony is unavailable the jury may be permitted to infer the defendant's negligence if the injury would not normally have occurred in the absence of someone's negligence, the defendant had exclusively controlled the situation, and there had been an absence of any contributory action on the part of the plaintiff.[16] This evidentiary rule has been applied in surgi-

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[10] Owens v. Brochner, 172 Colo. 525, 474 P.2d 603 (1970). *See generally* Comment, *Opening Pandora's Box? An Extension of the Discovery Rule to Negligent Diagnosis in Idaho*, 8 IDAHO L. REV. 370 (1972); authorities cited note 3 *supra*.

[11] PROSSER § 32; Note, *Medical Malpractice—Statute of Limitations Tolled Until Patient Can Reasonably Discover Foreign Object Negligently Left in His Body During Surgery*, 8 GA. ST. B.J. 244 (1971); 3 ST. MARY'S L.J. 111 (1971).

[12] D. HARNEY, MEDICAL MALPRACTICE 269 (1973); Kroll, *The Etiology, Pulse, and Prognosis of Medical Malpractice*, 8 SUFFOLK L. REV. 598, 612 (1974).

[13] PROSSER § 32, at 165.

[14] *Id.* at 165-66.

[15] *Id.* at 165.

[16] *Id.* §§ 39, 40.

cal cases where the plaintiff was anesthetized, the surgeon had exclusive control, and other testimony was not available.[17]

C. *Concomitant Expansion of Hospital Liability*

Hospitals historically avoided any liability for negligence based upon their status as a defendant under the doctrines of governmental or charitable immunity; however, courts have become more willing to disregard this traditionally immune status.[18] When a hospital has liability insurance and a judgment will not affect the hospital's trust fund or property, the doctrine of charitable immunity will not bar an action.[19] As the number of actionable suits against hospitals has increased, insurance costs and hospital charges to patients have also increased.[20]

A hospital's potential liability may also be expanded under the doctrine of respondeat superior. Under this doctrine the hospital, as an employer, may be held liable for a tort committed by an employee.[21] Nurses and ancillary personnel have usually been considered hospital employees, but physicians have traditionally not been so considered. Distinctions, however, have been made between staff and salaried hospital physicians and between administerial and medical functions of a salaried physician.[22]

The case of *Darling v. Charleston Community Memorial Hospital*[23] has been widely recognized as a potentially significant extension of a hospital's liability for physician negligence. In *Darling* the plaintiff was treated for a broken leg in the hospital emergency room. A general practitioner on emergency call casted the leg, which subsequently became swollen, discolored, and very painful. The plaintiff later lost the leg because the pressure of swelling tissue inside the cast impaired his circulation. The court held the hospital liable and found that liability could be supported under two theories. First, the hospital failed to fulfill its

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[17] Ybarra v. Spangard, 25 Cal. 2d 486, 154 P.2d 687 (1944).

[18] PROSSER §§ 131, 133; Comment, *Hospital Liability for the Negligence of Physicians: Some Needed Legal Sutures*, 26 U. FLA. L. REV. 844 (1974).

[19] Michard v. Myron Stratton Home, 144 Colo. 251, 355 P.2d 1078 (1960); O'Connor v. Boulder Colo. Sanitarium Ass'n, 105 Colo. 259, 96 P.2d 835 (1939).

[20] AMA, MALPRACTICE IN FOCUS 21, 32 (1975) [hereinafter cited as AMA REPORT].

[21] PROSSER § 69.

[22] *See* Comment, *The Hospital and the Staff Physician—An Expanding Duty of Care*, 7 CREIGHTON L. REV. 249 (1974); Comment, *supra* note 18.

[23] 33 Ill. 2d 326, 211 N.E.2d 253, *cert. denied*, 383 U.S. 946 (1965).

traditional duty to provide an adequate number of nurses to monitor patients and report a patient's worsening condition to the attending physician. Under the second theory, the hospital failed to fulfill a duty to supervise physicians and require consultations. Since this second theory is based upon an expansion of the hospital's *own* duty of care, and since the physician was not a salaried employee of the hospital,[24] *Darling* may have extended a hospital's liability beyond the respondeat superior doctrine.[25]

D. *Medical Product Liability Limited by Statute and Decision*

There have been doctrinal expansions of liability for both medical products and medical services; under the expanding products liability doctrine, courts have emphasized "no-fault" injury; under the expanding services liability doctrine, courts have emphasized "discovery" of the injury. Both doctrines, however, have resulted in an increase in the total number of potentially actionable injuries. For example, a potentially actionable injury may occur under an expansive product liability doctrine where defective whole blood is used for transfusions.

At the present time no positive method exists for detecting hepatitis virus in whole blood; while the hepatitis virus is identifiable, the person responsible (the donor) cannot be identified, and there is no way to be sure that blood for a transfusion is "clean."[26] Although courts in some jurisdictions have held proper a strict liability tort action where a patient has received a blood transfusion that contained the hepatitis virus,[27] strict liability for "unclean" blood has been sharply limited in Colorado, first by the courts[28] and then by legislative action.[29]

In *Allen v. Ortho Pharmaceutical Corp.*[30] the United States District Court for the Southern District of Texas held that the

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[24] *See* Comment, *supra* note 18, at 850 & n.56.

[25] Walkup & Kelly, *Hospital Liability: Changing Patterns of Responsibility*, 1974 INS. L. 333, 338-40 (1974); Comment, *The Hospital and the Staff Physicians—An Expanding Duty of Care*, 7 CREIGHTON L. REV. 249, 252-55 (1974).

[26] Schmaltz v. St. Luke's Hosp., 33 Colo. App. 351, 354, 521 P.2d 787, 789 (1974), *rev'd in part, aff'd in part*, 534 P.2d 781 (1975).

[27] Cunningham v. MacNeal Memorial Hosp., 47 Ill. 2d 443, 266 N.E.2d 897 (1970), *modifying* 113 Ill. App. 2d 74, 251 N.E.2d 733 (1969).

[28] St. Luke's Hosp. v. Schmaltz, 534 P.2d 781 (Colo. 1975).

[29] COLO. REV. STAT. ANN. § 13-22-104 (1973).

[30] 387 F. Supp. 364 (S.D. Tex. 1974).

statute of limitations (and also lack of privity) prevented the plaintiff from recovering for an injury caused by taking birth control pills. Eight days after the plaintiff commenced taking the pills, she became ill and was hospitalized. The court used the date that the plaintiff was first hospitalized for the illness to begin running the statute of limitations, rather than a date approximately four months later when she was told by her doctor that the defendant's pills had probably caused her illness.

By holding that the cause of action accrued from the date of the injury, the court chose not to apply the discovery rule expansively. While this suit was against a manufacturer, the court noted and followed the usual Texas court application of the discovery rule in medical malpractice cases, limiting the rule to cases of fraudulent concealment or where foreign objects are left in the body during surgery.[31] In explaining its rationale for using this date to commence the running of the statute, the court stated:

> Although plaintiff may not have had actual knowledge of the cause of her illness at that time, her symptoms were sufficient to permit her to discover the source if she had acted with reasonable diligence.[32]

Thus, the court in *Allen* shifted the emphasis to the *patient's duty* to act with reasonable diligence to discover the source of an injury. This recognizes the sophistication of today's average health care consumer,[33] and, therefore, the type of patient behavior to be deemed reasonable, as well as the possible need to rebalance the plaintiff-defendant equities in strict medical product liability.

II. MEDICAL SERVICES LIABILITY—THE MEDICAL MALPRACTICE PROBLEMS

Problems relating to both medical malpractice and medical malpractice insurance are not new, but recently they have intensified in the following interrelated areas: The increasing frequency of malpractice claims; the increasing costs and decreasing availability of medical malpractice insurance to protect health

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[31] *Id.* at 366.

[32] *Id.*

[33] A. SOMERS, HEALTH CARE IN TRANSITION: DIRECTIONS FOR THE FUTURE 81 (1971) [hereinafter cited as SOMERS].

care providers against the increasing claims; the tensions that exist between what a physician and a court may deem as proper medical care; the limited health care personnel and resources presently available; and a rapidly changing societal milieu.[34] When these factors are viewed simultaneously, the result is popularly called the "malpractice crisis."[35] While the word "crisis" may have assumed a quotidian quality in English, in Chinese the word "crisis" is written in two characters; one means *danger* and the other means *opportunity*.[36]

Senator Daniel Inouye, noting both the increased numbers of medical malpractice claims and the increased costs of medical malpractice insurance, compared the figures from 1960 to 1975 as follows:

> [T]en years ago, about 6,000 malpractice claims were filed each year. By 1970 this number had risen to approximately 10,000 to 12,000, and today, it has been estimated . . . from 15,000 to 20,000 such claims are opened annually. . . .
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> In the period 1960-1970, nonsurgeon physician premiums went up 540.8 percent, surgeon premiums 950 percent. Each year since 1970 has seen an additional increase of about 80 percent . . . .[37]

There is a very real possibility that medical malpractice insurance coverage may no longer be offered at all by private insurance companies, or, if it is offered, that rates will become exorbitant.[38]

A. *Sources of the Problem*

There is no single causative factor or reason for the sudden and disruptive malpractice crisis phenomenon. Some of the reasons that have been suggested are: The increased number of people receiving health care services in this country; the changing medical services as new drugs and new procedures introduce new

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[34] *Id. See* COMMISSION ON MEDICAL MALPRACTICE, U.S. DEPT. OF HEALTH, EDUCATION AND WELFARE, MEDICAL MALPRACTICE 5-20 (1973) [hereinafter cited as HEW REPORT].

[35] *Id.*; AMA REPORT 11.

[36] SOMERS vii, *citing* Romano, J.A.M.A., Oct. 26, 1974.

[37] STAFF OF HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94TH CONG., 1ST SESS., AN OVERVIEW OF MEDICAL MALPRACTICE 100-01 (Comm. Print 1975) [hereinafter cited as COMM. PRINT].

[38] *Id.* at 6; AMA REPORT 22-23. Senator Inouye has suggested that exorbitant rates will either be passed on to the consumer or will be so prohibitive that physicians may be forced to retire or withdraw from the health care system. COMM. PRINT 101.

risks of injury; and the changing and redefined expectations of health care consumers and providers.[39]

Under new health care programs, over twenty million persons, including the elderly and medically indigent, are receiving noncharity medical care for the first time in their lives.[40] The American Medical Association now recognizes the need for more physicians.[41] From 1960 to 1970 twenty new medical schools were started and health paraprofessional programs commenced; nevertheless, the physician shortage may account for a part of the problem.[42] Some medical experts have attempted to increase physician productivity by encouraging greater systemization, perhaps at the expense of quality. This may also have led to a deterioration in the physician-patient relationship.[43]

Drug testing and quality controls are more rigorous than they have been in the past,[44] but, with new drugs and procedures being discovered, a correlative number of new injuries may occur. Medical discoveries, treatments, and cures receive wide publicity, but all diseases are not curable and all patients are not cured, even when the recommended treatment protocols are followed. Suggestions that the increasing number of medical malpractice claims may be related to a sudden increased incidence of physician malpractice or to a contingent fee system used by lawyers lack merit;[45] the Secretary of HEW's Commission on Medical Malpractice found that it is an "inescapable fact that modern high-quality medicine carries risks that unavoidably result in some injuries to patients, no matter how much care, skill and judgment is applied."[46]

The popularly expected "right to health" has effectively masked part of the problem.[47] It "is very misleading [since it] suggests that society has a supply of 'health' stored away"[48] which

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[39] COMM. PRINT 100.
[40] SOMERS 3.
[41] *Id.* at 8.
[42] *Id.* at 3, 8, 9.
[43] *Id.* at 9.
[44] *Id.* at 3.
[45] HEW REPORT 32-33.
[46] *Id.* at 24.
[47] SOMERS 21.
[48] Fuchs, *The Jungle or the Zoo: What Price Health?*, MED. ECON., Apr. 28, 1975, at 160, 185.

can be given to individuals on demand. The number of patients has increased, patient demands have increased, and pressures on physicians have increased.[49] Traditionally, physicians have accepted heavy, self-imposed burdens in order to be available to their patients. However, physicians as well as consumers have become more sophisticated, and today's physicians are reexamining their traditionally accepted duty to be available.[50]

B. *Medical Malpractice Insurance*

This past year, as medical malpractice insurance problems became more acute in terms of the cost and the availability of coverage, physicians in New York, Miami, and San Francisco temporarily withheld nonemergency services.[51] Unwilling to quietly pass added insurance costs on to their patients, they have effectively focused attention on the medical malpractice insurance issues.[52]

Two major types of medical malpractice insurance are available: An "occurrence" policy covering claims from acts that occurred during the policy period, whenever filed; and a "claims made" policy that will only cover claims reported during the year that the policy is in force.[53] While lawyers, architects, and other professionals have traditionally had "claims made" policies, since medical malpractice claims for personal injury may not be as discoverable as nonpersonal injury claims against other professionals and may not, therefore, be discovered until long after the

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[49] SOMERS 6, 7, 25. Figures indicate an increase in the number of physicians in relation to population, but this is misleading because factors not considered include the increasing proportion of specialists, the uneven geographic distribution of physicians, and the increasing numbers of foreign physicians who are not in this country permanently, but only to complete their training. *Id.* at 7. Paradoxically, as patients become healthier, longer lived, and more affluent, they need and demand *more* health care, yet they also become more critical of the care they receive. *Id.* at 18-25.

[50] Schwartz, *The Changing Compact Between American Doctors and Society*, MODERN MED., June 15, 1975, at 32.

[51] *Id. See also* Rocky Mountain News, Jan. 17, 1976, at 41, col. 3. *But see* Hendricks, *They Won Malpractice Relief—Without a Walkout*, MED. ECON., Oct. 13, 1975, at 31 (description of response to these problems by Louisiana physicians).

[52] Schwartz, *supra* note 50. The malpractice crisis has prompted a "Proposed Federal Solution"—the National Medical Malpractice Insurance and Arbitration Act of 1975 (S. 482) introduced by Senators Edward Kennedy and Daniel Inouye; authorities cited, *supra* notes 37, 38.

[53] Hendricks, *What Your Next Malpractice Policy May Look Like*, MED. ECON., Apr. 14, 1975, at 29.

alleged negligence, physicians have traditionally carried an "occurrence" policy. To cover all the potential claims under an "occurrence" policy, insurance companies need a large reserve fund, popularly referred to as the "long malpractice tail."[54] However, while insurance companies acknowledge that the "villain is that long claims 'tail',"[55] most of them have also predicted that a "claims made" policy premium will be as high as an "occurrence" policy premium in five years.[56] Since an "occurrence" policy provides more than one year's protection and a "claims made" policy provides only one year's protection, it is difficult to understand how their costs could be equal.[57]

In a report prepared for the Colorado Medical Society, the Hartford Insurance Company explained its rate increase for Colorado physicians in 1975 as follows: Physicians purchasing the minimum coverage of $100,000 had a rate increase of 15 percent *based upon the experience in Colorado,* but physicians purchasing $1 million coverage had a rate increase of 40 percent *based upon the country-wide phenomenon.*[58] The Colorado Medical Society expects another rate increase of 94 percent in 1976.[59] If the medical malpractice insurance problems are not solved, insurance companies may choose to leave the medical malpractice marketplace, physicians may prefer to start their own insurance companies, or legislatures (federal or state) may choose to regulate the field.[60]

While they generally oppose any changes in traditional legal doctrines and procedures, the Association of Trial Lawyers of America (ATLA) has stated that medical malpractice insurance

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[54] *Id.*

[55] *Id.* at 35.

[56] AMA REPORT 22-23; Hendricks, *supra* note 53, at 35.

[57] Hendricks, *supra* note 53, at 35. One approach to this problem is offered by Judge Jamison who reasonably proposes that insurance companies be limited to pools based upon claims successfully prosecuted by a statutory formula. Interview with Judge Francis Jamison, Professor, University of Denver College of Law, Denver, Colo.

[58] Warren & Sommer, Inc., Colorado Medical Society Professional Liability Insurance Program (undated 1975 report on file with the Colorado Medical Society). Both physicians and legislators in Colorado may question rate increases *not* based upon or justified by the Colorado experience.

[59] The Denver Post, Mar. 5, 1976, at 21, cols. 3, 4, 5 (statement by Colorado Medical Society).

[60] MED. WORLD NEWS, June 16, 1975, at 20, 21, 22; AMA REPORT 22-23.

must be made available at a reasonable cost,[61] and has suggested eliminating rate classifications between different risk medical specialities, requiring deductibility clauses, and eliminating the insured's consent as a condition for settlement.[62] Legislation of this type, permitting an insurance company settlement without the insured's consent, may involve questions of constitutional dimension. The proposals may be a denial of the physician's equal protection and due process rights, but they are consistent with the ATLA's position that "[t]he interests of the patient-consumer must be paramount over those of the health care provider, the lawyer, or the insurance carrier."[63] The American Medical Association (AMA) agrees with the ATLA that medical malpractice insurance must be made available at a reasonable cost, but the AMA suggests the creation of a workmen's-compensation-type program as an alternative to litigation.[64]

C. *Defensive Medicine*

As the physician's potential liability has expanded, new public policy questions have surfaced that are not yet answered. For example, a fear of medical malpractice actions can lead physicians to practice defensive medicine—order lab tests and diagnostic procedures at additional cost and possible risk to the patient to avoid a hindsight accusation of missing an unlikely diagnosis for lack of thoroughness.[65]

Although physicians are aware of defensive medicine's higher costs and nonessential utilization of scarce medical resources,[66] hard cases may make *bad medicine,* as well as *bad law.* In *Helling v. Carey,*[67] the Washington Supreme Court unanimously held as a matter of law that the defendant ophthalmologists should have given the plaintiff a pressure test for glaucoma in spite of *uncontradicted* testimony by plaintiff's and defendants' witnesses that established defendants' compliance with the stan-

[61] Markus, *A Position of Responsibility,* TRIAL, May/June 1975, at 49, 50 (position paper prepared by ATLA).

[62] *Id.* at 50-51.

[63] *Id.* at 57.

[64] AMA REPORT 27.

[65] COMM. PRINT 105.

[66] *Id.* at 6.

[67] 83 Wash. 2d 514, 519 P.2d 981 (1974).

dards of the profession of ophthalmology which did *not* require *routine* pressure testing for glaucoma in patients under 40 years of age.

The plaintiff had first consulted the physician for nearsightedness and had been fitted with contact lenses in 1959.[68] The first time the plaintiff complained of a visual field problem was in 1968; at that time the defendant tested the plaintiff's eye pressure and subsequently made the diagnosis of glaucoma.[69] The plaintiff was 23 years old at the time of her first visit; the incidence of glaucoma in people under age 40 is one in 25,000; in people over age 40 the incidence is two or three percent.[70]

Although the plaintiff's "theory of the case" had not included the adequacy of the ophthalmologic standards of care,[71] the trial judge had refused the plaintiff's proposed instructions defining these standards, and it was this error that the plaintiff appealed.[72] The majority opinion stated that the pressure test was relatively inexpensive and simple, and, therefore, the court decided as follows:

> The precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma.
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> We therefore hold, as a matter of law, that the reasonable standard that should have been followed . . . was the timely giving of this simple, harmless pressure test to this plaintiff and that, in failing to do so . . . the defendants are liable.[73]

After reviewing the current *medical* literature on the diagnosis and treatment of glaucoma, Dr. Ray Bradford, an ophthalmologist, made the following observations:

> The measurement of intraocular pressure by . . . tonometer . . . or . . . applanometer . . . is well known . . . and is used . . . in clinical practice.
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> . . . .

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[68] *Id.* at 515, 519 P.2d at 981.
[69] *Id.* at 516, 519 P.2d at 981.
[70] *Id.* at 518, 519 P.2d at 983.
[71] *Id.* at 521-22, 519 P.2d at 985 (concurring opinion).
[72] *Id.* at 516-17, 519 P.2d at 982.
[73] *Id.* at 519, 519 P.2d at 983.

> There are, however, instances when it is not easy to get accurate results and times when *the test itself can be traumatic and injurious*. . . .[74]

Dr. Bradford described instances when pressure tests are *contra-indicated*, listed the preferred diagnostic procedures, and suggested that new studies indicate treatment should be withheld until glaucomatous damage is definitely established.[75] In addition to risks inherent in the pressure test procedure itself, Dr. Bradford noted that the predictive value of the test to diagnose glaucoma is now questionable and that it is being done on a smaller scale today since it is less valued as a screening procedure.[76] He concluded that the test is not definitive and suggested that a judgment in each case determine the use and choice of instrumentation.[77] Since a general anesthetic may be required to test a child under age 14, anesthetic risks must also be considered in determining whether the procedure should be performed.[78]

The court in *Helling* noted that the issue—the ophthalmologic standard of care—was *not* argued at the trial.[79] Nevertheless, the court concluded on the basis of evidence that had been presented that the standard had been premised solely on the lower incidence of glaucoma in people under age 40.[80] Had the issue been argued at the trial level, the record might have shown the other factors to be considered, and the court might have reached a different decision.

The testimony given *did* indicate that the professional standards *required* the test to be given *if* the patient's complaints and symptoms revealed that glaucoma should be suspected.[81] Since

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[74] Bradford, *A Unique Decision*, 2 J. LEGAL MED., Sept./Oct. 1974, at 52, 53 (emphasis added).

[75] *Id.* at 54.

[76] *Id.*

[77] *Id.* at 55.

[78] Interviews with pediatricians and ophthalmologists in the Denver area. The physicians interviewed indicated that the physicians in *Helling* may have been negligent under medically accepted standards of care which are not absolute. There may or may not have been enough questions directed to the physician-witnesses on the issue of whether or not any of the specific earlier complaints of the plaintiff would or *might* have warranted an earlier testing for glaucoma *under* the medical standards, since her case may not have been routine.

[79] 83 Wash. 2d at 516-17, 519 P.2d at 981-82.

[80] *Id.* at 516, 519 P.2d at 982.

[81] *Id.*

the record did not contain evidence as to whether or not glaucoma should have been suspected in this case or if the test *could* have been timely and safely given to this plaintiff, the case could have been remanded.[82]

Medicine depends upon the individualization of standards; a physician, like Justice Cardozo, "struggles in vain for any verbal formula that will supply a ready touchstone."[83] It is too early to measure the effects of the *Helling* decision, but, when a court presumes to determine proper medical care, it has assumed a heavy responsibility.[84]

III. MEDICAL SERVICES LIABILITY—POSSIBLE SOLUTIONS

A. *Alternatives to Litigation*

In the past few years no-fault or strict liability plans[85] and arbitration or screening panels[86] have been suggested as alternatives to the present litigation system.[87] While a no-fault or strict liability plan could provide compensation to more injured persons, it would be impractical in medical malpractice cases; cost figures cannot be estimated and there are problems in determining causation.[88] Since the eventual costs could be prohibitive, the

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[82] *Id.* at 518, 519 P.2d at 983; *see* note 78 *supra.*

[83] Welch v. Helvering, 290 U.S. 111, 115 (1933).

[84] *See* note 78 *supra*; Comment, *Physicians and Surgeons—Standard of Care—Medical Specialist May be Found Negligent as a Matter of Law Despite Compliance with the Customary Practice of the Specialty*, 28 VAND. L. REV. 441 (1975); Comment, *Torts—Medical Malpractice—Judicially Determined Standard of Care*—Helling v. Carey, 20 N.Y.L.F. 669 (1975); Note, *Medical Malpractice—Compliance with Professional Standards Does Not Necessarily Absolve Ophthalmologist from Liability for Negligence in Failing to Diagnose and Treat Glaucoma*, 6 TEX. TECH. L. REV. 279 (1974). *But see* Note, Helling v. Carey: *Medical Malpractice Standard of Care Determined by Court*, 11 WILLAMETTE L.J. 152 (1974).

[85] Havighurst & Tancredi, *"Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance*, 1974 INS. L.J. 69; O'Connell, *An Elective No-Fault Liability Statute*, 1975 INS. L.J. 261; *see* Comment, *Medical Malpractice: A Move Toward Strict Liability*, 21 LOYOLA L. REV. 194 (1975).

[86] Lillard, *Arbitration of Medical Malpractice Claims*, 26 ARB. J. 193 (1971); Morris, *Medical Report: Malpractice Crisis—A View of Malpractice in the 1970's*, 38 INS. COUNSEL J. 521 (1971); Note, *The Medical Malpractice Mediation Panel in the First Judicial Department of New York: An Alternative to Litigation*, 2 HOFSTRA L. REV. 261 (1974).

[87] *See generally* King, *A Commentary on the Report of the Malpractice Commission*, 29 RECORD OF N.Y.C.B.A. 294 (1974); Kroll, *The Etiology, Pulse and Prognosis of Medical Malpractice*, 8 SUFFOLK L. REV. 598 (1974); Lanzone, *A Defense Lawyer Views Product Liability and Professional Liability No-Fault*, 1975 INS. L.J. 82.

[88] *See* COMM. PRINT 32. Robert Keeton suggested that the problems with the no-fault medical injury concept will be in determining awards, not because of the negligence issue

benefits provided by this type of plan may in fact be chimerical.

Both compulsory and elective arbitration or mediation panels have merit as screening panels and should be further studied and considered by medical, legal, and legislative groups.[89] However, the lack of sufficiently protective evidentiary rules, which may not be overcome on review, limits the value of screening panels as a settlement procedure in lieu of a trial.

B. *Legislation—The Indiana Model*

Recognizing the impact of medical malpractice insurance problems on both health care providers and health care consumers, in 1975 federal and state legislatures studied, proposed, and/or enacted remedial statutes.[90] For example, the Indiana legislature enacted a comprehensive statute specifically addressing the medical malpractice issues.[91]

1. The Statute of Limitations

The Indiana statute of limitations now limits all claims in tort and contract against health care providers[92] to 2 years from the date of the alleged act, failure to act, or neglect.[93] A minor under age 6 is given until age 8 to file, but otherwise the section is specifically stated to apply to all, regardless of minority or legal disability.[94] A parent or a court-appointed guardian is not required by the statute to act on behalf of an injured child or one who is legally disabled.[95] When compared to the current Colorado statutes,[96] conspicuously, though perhaps purposefully, lacking are any provisions relating to discovery of the negligent act.

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but because of difficulties in determining causation; also, there can be no idea of the costs that might be involved.

[89] *See* authorities cited, note 86 *supra.*

[90] *See* COMM. PRINT; Rhein, *Malpractice: Grim Outlook for '76,* MED. WORLD NEWS, Jan. 12, 1976, at 71.

[91] IND. CODE §§ 16-9.5-1-1 to -9-10 (Supp. 1975). The Indiana Act is called the "brightest" spot in legislation for medical malpractice. MED. WORLD NEWS, June 16, 1975, at 20.

[92] The Indiana Act defines a "health care provider" to include

> a person, corporation, facility or institution licensed by this state . . . as a physician, hospital, dentist . . . nurse, optometrist, podiatrist, chiropractor, physical therapist or psychologist, or an officer, employee, or agent thereof acting in the course and scope of his employment.

IND. CODE § 16-9.5-1-1(a) (Supp. 1975).

[93] *Id.* § 16-9.5-3-1.

[94] *Id.*

[95] *See id.*

[96] COLO. REV. STAT. ANN. §§ 13-80-105, 13-81-101 to -103 (1973).

The Colorado statute of limitations[97] limits commencement of actions against health care providers to 2 years after a person discovers, or with reasonable diligence and concern should have discovered, his injury. Although one is required to exercise "reasonable diligence and concern to discover" and must commence an action within 6 years of the act or omission complained of, an exception is made for unauthorized or foreign objects left in the body.[98] This 6-year limit could reasonably be reduced to 4 years.[99] However, under the Colorado disability statutes, unless the court has appointed a guardian for a minor, the applicable statute of limitations is tolled for a minor until the minority is terminated.[100] By statutory fiat, Colorado defines a legal representative as "a guardian, conservator, executor, or administrator duly appointed by a court . . . ."[101] Since the word "guardian" does not encompass parents, by adding the words "the parent of any child born or adopted" before the words "a guardian," the statute would recognize parents as the legal representatives of their children, and the personal injury statute of limitations would not be tolled automatically for most minors.[102]

Although a minor is certainly capable of owning property or a cause of action, he is incapable of effectively dealing with it. When a minor is required to file an income tax return for earned income, if he is unable to complete the return himself, his parent or guardian has an affirmative duty to file it for him.[103] While a personal injury suit may not be obligatory, a parent or guardian could be encouraged to file on behalf of the child. In this way an injured child might be better protected, and any expensive rehabilitation or continued care treatments would not need to be postponed. In addition, tolling the statute for minors only up to age 7 effectively docks the long malpractice tail by 11 years. The statute of limitations should specifically state that it applies to

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[97] *Id.* § 13-80-105.

[98] *Id.*

[99] *See* COMM. PRINT 197; ch. 75-9, § 7, [1975] Fla. Sess. Laws 20, *amending* FLA. STAT. § 95.11 (Supp. 1975).

[100] COLO. REV. STAT. ANN. §§ 13-81-101 to -103 (1973).

[101] *Id.* § 13-81-101(2).

[102] Under current Colorado law a personal injury action can be brought up to 27 years after an injury to a newborn infant. *See* Johnson v. Dodrill, 265 F. Supp. 243 (D. Colo. 1967).

[103] INT. REV. CODE OF 1954, § 6012(b)(2); Treas. Reg. § 1.6012-1(a)(4) (1975).

minors over age 7, and that a parent, or a court-appointed guardian for a minor under age 7, has until the minor's ninth birthday in which to file. While Indiana chose age 6, age 7 would seem more reasonable, because by age 7 a physical or mental handicap is usually recognized by the school, testing is more reliable, and the child is better protected than he would be at age 6.[104] Although age 6 to 7 is only 1 year, developmentally it is quite significant.[105]

2. The *Ad Damnum* Clause

The *ad damnum* clause of a complaint names the specific total dollar amount of damages claimed.[106] Since the amount claimed in the *ad damnum* clause bears little relationship to the amounts actually obtained or even expected, and since an inflated *ad damnum* clause attracts notoriety and sensational newspaper coverage, it has been suggested that states should enact laws to eliminate dollar amounts in the *ad damnum* clause for medical malpractice claims, while allowing admission of evidence of specific actual damages at the trial.[107] Indiana eliminated the *ad damnum* clause for medical malpractice actions;[108] other states, including Colorado, might follow a similar format.[109]

3. A Limited Recovery

The Indiana Act limits a plaintiff's recovery for malpractice to $100,000 from any one health care provider and the total amount recoverable for any injury or death to $500,000.[110] Any amount due from a judgment or settlement in excess of the total liability of all health care providers, up to the $500,000 allowed, is to be paid from a state compensation fund.[111] Although the constitutionality of statutes limiting awards has been questioned,

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[104] W. NELSON, TEXTBOOK OF PEDIATRICS (7th ed. 1959); D. WECHSLER, WECHSLER INTELLIGENCE SCALE FOR CHILDREN (Manual) at 13, 14, 20, 21 (1949); Grossman, *Symposium on Learning Disorders*, 20 PEDIATRIC CLINICS OF N. AM., Aug. 1973.

[105] *See* authorities cited note 104 *supra*.

[106] BLACK'S LAW DICTIONARY 56 (4th ed. rev. 1968).

[107] HEW REPORT 38.

[108] IND. CODE § 16-9.5-1-6 (Supp. 1975).

[109] *See* HEW REPORT. *See also* ch. 75-9, § 8, [1975] Fla. Sess. Laws 21, creating section 768.042 which prohibits the stating of the amount of general damages in any complaint for recovery of damages for personal injury or wrongful death.

[110] IND. CODE § 16-9.5-2-2 (Supp. 1975).

[111] The fund is created by levying a surcharge on all health care providers in Indiana, the levy limited to 10% or less of the yearly cost of each provider's liability coverage. *Id.* § 16-9.5-4-1. The pool of funds is limited to approximately $15 million. *Id.* § 16-9.5-4-1(f).

the arguments to support these doubts are not persuasive.[112] For example, in Colorado one's right to sue may be limited by statutes proscribing theories under which one may sue,[113] the time in which one may sue,[114] or the amount for which one may sue.[115] The Colorado Supreme Court, in upholding the validity of a time-limiting statute for medical malpractice in *McCarty v. Goldstein*[116] explained as follows:

> The classification of . . . professions for limitation or regulation is a matter for legislative determination, and when based upon reasonable grounds will not be interfered with by the judiciary.[117]

Legislation that is reasonably related to the public health and safety may provide equal protection as well as procedural due process and be upheld constitutionally under several theories: An implied consent to limit damages; an implied contract to limit damages; or the general police power of the state.[118] If a fair and reasonable procedure is provided, due process is satisfied; there is little reason to doubt the validity of reasonable statutory time limits or damage award limits that apply to both adults and minors, particularly if concomitant legislation requires health care providers to carry liability insurance.[119]

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[112] Curran, *Law-Medicine Notes: The Malpractice Insurance Crisis: Short-term and Long-term Solutions*, 293 NEW ENG. J. MED., July 3, 1975, at 24, 25. (The arguments are not persuasive because support is essentially nonexistent.)

[113] COLO. REV. STAT. ANN. § 13-22-104 (1973) (prohibiting any no-fault recovery for injuries due to transplants or transfusions).

[114] *Id.* §§ 13-80-101 to -81-107 (various statutes of limitations).

[115] *Id.* § 8-42-204 (limits damages for personal injury resulting solely from negligence of a coemployee to $25,000).

[116] 151 Colo. 154, 376 P.2d 691 (1962).

[117] *Id.* at 158, 376 P.2d at 693.

[118] School Dist. No. 1 v. Industrial Comm'n, 66 Colo. 580, 185 P. 348 (1919). The Workmen's Compensation Act was passed under the police power of the state. *Cf.* Day-Brite Lighting, Inc. v. Missouri, 342 U.S. 421 (1952) (the Court notes the broad and inclusive concept of public welfare and that debatable issues of public welfare should be left to legislative decision).

[119] *See* Finn v. Industrial Comm'n, 165 Colo. 106, 110, 437 P.2d 542, 544 (1968), where the court affirms the legislature's power to provide a different remedy; the fact that a workmen's compensation award may deprive an injured person of compensation or a common law action does not make such a statute unconstitutional. *See also* O'Quinn v. Walt Disney Prods., Inc., 177 Colo. 190, 193, 493 P.2d 344, 345 (1972), where the court stated that "so long as a statute in abrogation of the common law does not attempt to remove a right which has already accrued, there is no taking."

In the case of a child who had been injured at birth and who is now five years old, the recommended law would not remove the right to sue; it would merely limit the time

C. *Legislation—Colorado*

If the legislature determines that a limitation on awards is prophylactically desirable in Colorado, the Indiana format appears reasonable. A less comprehensive, but sufficiently protective, legislative formula might combine a requirement that all health care providers carry a specified level of malpractice insurance with a limit on malpractice judgments to that statutory amount. The statutory limit would not apply to health care providers who fail to carry the specified coverage. At this time it is not possible to judge how these types of statutes will work; however, if insurance companies continue to base rates on the national experience, the effects of state legislation limiting the amount of an award may be negated.[120]

In 1975 the Colorado legislature passed three statutes affecting review of a physician's conduct. These statutes will enable physicians to institute disciplinary proceedings against a fellow physician without fear of retaliatory litigation.[121] A physician review committee may recommend disciplinary action to the Colorado State Board of Medical Examiners;[122] when such a recommendation is made, follow-up procedures are established to provide investigations, hearings, and determinations.[123] The Colorado Court of Appeals has initial jurisdiction to review actions taken by the board in revoking or suspending a license or in placing a physician on probation.[124] These codified procedures will ensure sufficient protection both for the physician accused and the health care consumer, since physicians will be able to discipline themselves more effectively.[125] The present Colorado statutes also allow incorporated physicians to limit their liability for a corporate associate's negligent malpractice, if the required

within which that right could be exercised and, therefore, since it would not amount to a taking, could be applied retroactively. *See* note 131 and accompanying text *infra*.

[120] *See* note 59 and accompanying text *supra*.

[121] COLO. REV. STAT. ANN. §§ 12-43.5-101 to -103 (Supp. 1975), provides the members of the review committee with immunity from any civil action if they act in good faith.

[122] *Id.* § 12-43.5-102(3)(d).

[123] *Id.* §§ 12-36-118(1), (2).

[124] *Id.* § 12-36-119(2).

[125] Physician-representative Frank Traylor should be commended for his leadership in sponsoring this type of legislation. Dr. Traylor is presently studying a pretrial screening panel to enable an injured party to sue a proper defendant and to eliminate frivolous claims.

statutory formalities are followed and if the professional corporation or the physician himself carries the required minimum malpractice insurance.[126]

The Colorado Legislative Committee on Medical Malpractice has prepared several bills for consideration in 1976; however, the committee has failed to recognize some of the crucial issues involved[127] and, in attempting to protect consumers, concomitant rights of health care providers have been ignored.[128] One of the proposed bills provides that the patient records in a physician's office, including the physician's work product notes to himself, shall be available to the patient, or a copy made upon payment of a reasonable fee. (There is an exception made for psychiatric or psychological problems; in these cases a summary rather than a copy must be provided.)[129]

Proposed legislation for Colorado should include statutes limiting the amount of pooled reserves that insurance companies can maintain and/or a program similar to Indiana's so that health care providers can self-insure. Additional insurance company regulatory statutes might also be considered, since, out of each dollar presently collected for medical malpractice insurance, between 62

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[126] COLO. REV. STAT. ANN. § 12-36-134(1)(g) (Supp. 1975), requires the articles of incorporation of a professional service corporation for the practice of medicine to provide that all shareholders (physicians) are jointly and severally liable for employee acts *or* that they are exempt when they maintain professional liability insurance that meets listed minimum standards. This type of legislated minimum liability insurance standard was upheld in Walkovzsky v. Carlton, 18 N.Y.2d 414, 276 N.Y.S.2d 585, 223 N.E.2d 6 (1966).

[127] Rep. Frank Traylor, M.D., committee member, stated that the committee was hostile to physicians and concentrated on consumer (patient) problems. Rocky Mountain News, Jan. 11, 1976, at 30, col. 1.

[128] COLO. COMM. ON MEDICAL MALPRACTICE INTERIM REPORT (1975-1976). Contained in the INTERIM REPORT is Proposed Bill H-1 which would amend the COLO. REV. STAT. ANN. as follows: Section 10-4-804 would require health care providers to purchase professional liability insurance in the amount of one hundred thousand dollars per occurrence as a basic coverage (this is not the same amount that is required by the professional corporation statute); section 10-4-803(1) would authorize the commissioner to levy an annual surcharge on all health care providers for an extraordinary loss fund; section 10-4-803(2) would state that failure to purchase the basic coverage or to comply with the other provisions shall result in the suspension or revocation of a health care provider's license; section 10-4-804(5) would authorize the commissioner to defend, litigate, settle, or compromise any claim in excess of the basic coverage (the insured's consent as a condition for settlement is eliminated). Proposed Bill H-1 does not consider the *ad damnum* clause.

[129] *Id.* Proposed Bill E.

and 84 cents goes to the insurance companies for costs and profit.[130]

In any legislation, since it is "well established that statutes of limitation . . . will not be given retroactive application in the absence of an express direction from the legislature to do so,"[131] it is suggested that the legislature expressly provide for any desired retroactive application.

D. *Judicial Action*

The Colorado Supreme Court has shown acumen in its responses to rapidly changing societal demands,[132] and restraint in cases dealing with the liability of hospitals. While *Moon v. Mercy Hospital*[133] was decided prior to the *Darling* case,[134] the court, under an independent contractor rationale, did not find the hospital liable for the actions of a staff physician; the court recognized that hospitals do not practice medicine and that strict liability would be inappropriate. Recognizing the inherently personal relationship between a physician and a patient, and refusing to make artificial distinctions between a staff physician and a hospital-employed physician, the Colorado Supreme Court did not apply a *Darling* type doctrine but stated:

> [T]he hospital cannot and does not practice medicine and, hence, cannot be charged with the careless and negligent performance of medical services by a doctor on the staff of the hospital or employed by the hospital . . . .[135]

St. Luke's Hospital v. Schmaltz[136] is a recent illustration of the court's restraint in dealing with hospital liability. The decision quoted the statutory language dealing with blood transfusions (although the statute itself was not effective on the date of the incident):

> [T]he imposition of legal liability without fault upon the persons and organizations engaged in such scientific procedures may inhibit

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[130] COMM. PRINT 15.

[131] Valenzuela v. Mercy Hosp., 34 Colo. App. 5, 9, 521 P.2d 1287, 1289 (1974).

[132] As the court of appeals notes in *Valenzuela*, in 1971 the Colorado legislature merely codified existing case law by incorporating the discovery rule. 34 Colo. App. at 9, 521 P.2d at 1289. *See* note 5 *supra*.

[133] 150 Colo. 430, 373 P.2d 944 (1962).

[134] See text accompanying note 23 *supra*.

[135] Moon v. Mercy Hosp., 150 Colo. 430, 433, 373 P.2d 944, 946 (1962).

[136] 534 P.2d 781 (Colo. 1975).

> the exercise of sound medical judgment and restrict the availability of important scientific knowledge, skills, and materials. It is, therefore, the public policy of this state to promote the health and welfare of the people by emphasizing the importance of exercising due care, and by limiting the legal liability . . . to negligence or willful misconduct.[137]

There had been no prior cases in Colorado extending hospital liability in this area, and the court chose not to do so in this decision.[138]

In *Owens v. Brochner,*[139] a leading Colorado medical malpractice case, the Colorado Supreme Court used the term "reasonable diligence" to describe a patient's duty to discover the physician's negligence.[140] *Brochner* indicates that whether the statute of limitations bars a particular claim is a fact question; thus, whether a plaintiff can reasonably be expected to know the cause of an injury is a question for the jury.[141] While this recognizes the fluidity of the "patient's duty" standard, the court's instructions to the jury could be determinative. When the *Brochner* ruling was applied in *Nitka v. Bell,*[142] the plaintiff's status as a layman was emphasized.[143] There may be a question of whether or not a layman (plaintiff) today can be justifiably ignorant; his behavior may need to be measured by rapidly changing standards.[144] Following *Brochner,* the Colorado legislators clarified the statute of limitations for actions against health care providers by substituting the words "discovered or in the exercise of reasonable diligence and concern should have discovered . . . his injuries and the negligence or breach of contract" for the word "accrued."[145]

In balancing the equities between physician and patient, the Colorado Supreme Court recognized that the burden of stale

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[137] *Id.* at 782.

[138] *Id.* at 783.

[139] 172 Colo. 525, 474 P.2d 603 (1970).

[140] *Id.* at 532, 474 P.2d at 607.

[141] *Id.* at 529, 474 P.2d at 605.

[142] 29 Colo. App. 504, 487 P.2d 379 (1971).

[143] *Id.* at 509, 487 P.2d at 381-82.

[144] *See* SOMERS 81. Since the discovery of insulin and its use in the physician-directed but patient-administered treatment for diabetes, there have been other equally complex and serious therapies that require a knowledgeable and responsible patient.

[145] *See* notes 5 & 132 *supra.*

claims is outweighed by the needs of a plaintiff (patient) to have his day in court.[146] In balancing the equities today, however, several new factors must also be considered. One factor is the substantive duty of a patient today. Professor Prosser, quoting Mr. Justice Holmes, notes that "the law takes no account of the infinite varieties of temperament, intellect and education . . . ."[147] Perhaps a patient should, therefore, be held to that degree of care generally to be expected from a reasonable and prudent person in the same or similar circumstances.[148] While the Colorado Supreme Court has noted that the degree of care to be expected is a jury question,[149] in any review of a lower court's ruling on a motion for a judgment *non obstante verdicto* or on the appropriateness of any jury instructions given or not given, the reviewing court must consider the level of sophistication of today's patient, because "the public is much better informed than it used to be, and it no longer regards a doctor's views as law."[150] Other medical-legal concepts such as informed consent also recognize the increased sophistication of today's health care consumer.[151]

A second factor to consider in balancing the equities between physician and patient is the duty of today's health care provider. The law does not require the impossible, yet today's rapidly changing situation may be latently presenting physicians with impossible choices. For example, in Michigan physicians found that the malpractice crisis and insurance costs were "affecting the availability and quality of the state's medical care to a critical degree."[152] In Colorado and other states with growing populations, there are not enough primary care physicians to meet the consumer demand.[153] A fatigued physician's failure to treat might be

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[146] Owens v. Brochner, 172 Colo. 525, 474 P.2d 603 (1970).

[147] PROSSER § 32, at 152.

[148] *Id.* at 151.

[149] Owens v. Brochner, 172 Colo. 525, 474 P.2d 603 (1970). *But see* Valenzuela v. Mercy Hosp., 34 Colo. App. 5, 521 P.2d 1287 (1974), where the court found that, even as a layman, the plaintiff should have known that she had a cause of action.

[150] TIME, June 16, 1975, at 49; COLO. SUP. CT. COMM. ON CIV. JURY INSTRUCTIONS, COLO. JURY INSTRUCTIONS § 15:8 (1969) (duty of patient to follow instructions). *See* notes 33 & 144 and accompanying text *supra*.

[151] SOMERS 81. The consumer must learn to prevent illness and also frequently to assist in his own care and treatment.

[152] Hendricks, *The $42,000 Premium that Closed a Practice*, MED. ECON., Apr. 28, 1975, at 142.

[153] *See* SOMERS 7.

deemed negligent, yet he might also be deemed negligent in attempting to treat. The lines of moral and legal culpability are fuzzy.

Third, and perhaps most important for a court to consider in balancing the equities, are the alternatives and public policy implications.

> While public policy requires that the general populace be protected in its dealings, it is submitted that public policy also commands that the medical practitioner be equally insulated in his pursuit of his profession.[154]

CONCLUSION

In order to meet the needs of health care providers and health care consumers, it is essential that the legislature work with the judiciary to provide a solution to the problem. Suggested statutory additions for Colorado may be summarized as follows: (1) Reduce the 6-year absolute limit in COLO. REV. STAT. ANN. § 13-80-105 (1973); (2) add to COLO. REV. STAT. ANN. § 13-81-101 (1973) the words "the parent of any child born or adopted" and, thereby, for purposes of COLO. REV. STAT. ANN. §§ 13-81-101 to -103 (1973), recognize a parent as the legal representative of a child; (3) specifically state that COLO. REV. STAT. ANN. § 13-80-105 (1973) applies to a minor over age 7, that a parent or court-appointed guardian for a minor under age 7 has until the minor's ninth birthday to file, and that a parent or court-appointed guardian of a minor over age 5 at the date of the act has at least 4 years from the effective date of the act within which to file; (4) eliminate the *ad damnum* clause for medical malpractice actions; (5) require health care providers to purchase minimum malpractice insurance coverage (allow physicians to set up their own companies to do this if needed), limit the maximum awards for medical malpractice injury cases to this amount, and limit insurance companies to rate-setting rationally related to those limits; and (6) expressly provide for retroactive application of these changes.

These suggested additions for Colorado are less dramatic than Indiana's new statute, but they would be compatible with

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[154] Comment, *Contractual Liability in Medical Malpractice*—Sullivan v. O'Conner, 24 DE PAUL L. REV. 212, 226 (1974).

Colorado's existing legislative framework and philosophy of promoting "the exercise of sound medical judgment [and] the health and welfare of the people . . . ."[155]

Following its established practice of attempting to balance the physician-patient equities, the Colorado Supreme Court fashioned a flexible tool in *Brochner*.[156] While the factors to balance have now changed—from the 1970 choice of stale claims or one patient's right to sue, to the more complex needs of all health care consumers for medical services—the court-fashioned tool of "should have discovered"[157] can be swiftly utilized to ensure fairness to both health care providers and health care consumers in a rapidly changing society.

The Secretary of the Department of Health, Education, and Welfare summarizes the situation as follows:

> The gradual expansion of the discovery rule to an increasing number of treatment-injury situations may have an adverse effect on other aspects of the malpractice problem, particularly in the area of establishing rates for malpractice insurance.
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> . . . .
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> Unquestionably, the trend . . . has been towards the imposition of greater liability on health care providers . . . . [T]his trend may be extended unreasonably and unfairly in the future . . . and . . . this is bound to have a deleterious effect on the delivery of health care.[158]

Although the courts have generally deferred to legislative pronouncements of public policy,[159] when a balancing of equities has required the courts to lead, they have done so.[160] Perhaps a court knows that a refusal to make a decision is in itself a decision.

Judith Steinberg Bassow

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[155] COLO. REV. STAT. ANN. § 13-22-104 (1973). For a unique approach to legislation in the malpractice area, see Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. BAR FOUNDATION RESEARCH J. 87, which suggests that there be a contractual limitation of damages between physician and patient. One problem with this suggestion is that the UNIFORM COMMERCIAL CODE, a relevant codification of commercial law principles, declares that a damages limitation for personal injury "is prima facie unconscionable . . . ." UNIFORM COMMERCIAL CODE § 2-719(3). Although Epstein's suggested legislation is imaginative and perhaps practical, it would be difficult to base it upon commercial practices and even more difficult to persuade legislatures and courts that it is *not* unconscionable.

[156] 172 Colo. 525, 474 P.2d 603 (1970).

[157] *Id.* at 532, 474 P.2d at 607.

[158] HEW REPORT 30-31.

[159] *See* Moon v. Mercy Hosp., 150 Colo. 430, 373 P.2d 944 (1962).

[160] Owens v. Brochner, 172 Colo. 525, 474 P.2d 603 (1970).