Maine Law Review

Volume 53 | Number 2 Article 10

June 2001

Latent Medical Errors and Maine's Statute of Limitations for Medical Malpractice: A Discussion of the Issues

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I. INTRODUCTION

Each year in the United States, between 44,000 and 98,000 hospitalized patients die as a result of medical errors.[1] Nearly a third of such errors are caused by negligence.[2] Although most of these negligent mistakes become apparent to patients or their families shortly after they occur, a few remain undiscoverable for an extended length of time.[3]

When medical errors lead to the misdiagnosis of diseases with long latency

1. INSTITUTE OF MEDICINE, TO ERR IS HUMAN 1 (Linda T. Kohn et al. eds., 1999) [hereinafter INSTITUTE OF MEDICINE]. These figures were extrapolated from data collected in two major studies addressing the incidence of hospital medical error and injury. David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado*, 38 MED. CARE 250 (2000) [hereinafter Studdert, *Utah-Colorado Study*]; Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 MED. CARE 261 (2000) [hereinafter Thomas, *Utah-Colorado Study*]; *see also* Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENGLAND J. MED. 370 (1991) [hereinafter Brennan, *Harvard Study*]; Lucian L. Leape et al., *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II*, 324 NEW ENGLAND J. MED. 377 (1991) [hereinafter Leape, *Harvard Study*]; *see also* PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY (1985) [hereinafter DANZON, MEDICAL MALPRACTICE] (assessing the incidence of negligent medical injury and subsequent claim filing in California during the 1970s). For detailed discussion of these studies, see *infra* Part III.C. Because these studies address only injuries and deaths occurring in hospitals, total morbidity and mortality secondary to medical error is likely much higher. INSTITUTE OF MEDICINE, *supra*, at 1-2. According to one analyst, medical errors actually produce upwards of 180,000 deaths annually in the United States. David Orentlicher, *Medical Malpractice: Treating the Causes Instead of the Symptoms*, 38 MED. CARE 247 (2000). Stated in individual terms, the figures show that approximately one out of every two hundred patients admitted to a hospital die as a result of medical errors they incur during their stay. Andrea Gerlin, *Unattainable Standards Impose Costly Pressure; When Perfection is Demanded by the Culture of Medicine and by the Public, Failure is Inevitable*, PORTLAND PRESS HERALD, Sept. 13, 1999, at A1.

2. Brennan, *Harvard Study*, *supra* note 1, at 370.

3. In this Article, medical "error" (or mistake) is defined as "the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning)." INSTITUTE OF MEDICINE, *supra* note 1, at 23. "Adverse events" are injuries "caused by medical management (rather than the underlying disease)." Brennan, *Harvard Study*, *supra* note 1, at 370. Adverse events resulting from medical errors are "preventable adverse events." INSTITUTE OF MEDICINE, *supra* note 1, at 24. "Negligent adverse events" are preventable events that "satisfy [the] legal criteria used in determining negligence." *Id.* Tort law defines medical negligence as a "failure to meet the standard of practice of an average qualified physician practicing in the specialty in question." Leape, *Harvard Study*, *supra* note 1, at 381. Negligence occurs when "the degree of error exceeds an accepted [medical] norm." *Id.* Thus, medical error is not necessarily equivalent to medical negligence. Error is, however, a necessary precursor to medical negligence.

periods,[4] patients may be delayed in obtaining appropriate treatment. For some, this delay is devastating. Those with certain forms of cancer, for example, are easily cured when the disease is caught early. But if misdiagnosed, their untreated malignancies can spread silently over the ensuing months and years.[5] When worsening symptoms finally lead to an accurate diagnosis, these patients often must then endure treatment that is not only more invasive but also less likely to produce a cure than if undertaken earlier.[6] Similarly, medical mistakes surrounding the delivery of a baby may not be discoverable until years later when they result in fetal injury or death during a subsequent pregnancy.[7] Clearly, such victims of "latent medical errors" are among the most blameless as well as grievously injured individuals who seek relief through the legal system. Nonetheless, in Maine, because medical malpractice actions are governed by a strict occurrence-based statute of limitations as opposed to a limitations period that does not begin to run until injuries become discoverable, these plaintiffs are also among the least likely to receive any compensation.[8]

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4. Latent illnesses include a spectrum of conditions and diseases in which a patient generally experiences minimal, if any, noticeable physical deterioration beyond presenting symptoms for an extended length of time, even as the underlying disease continues to advance. As a result, neither the patient nor the health care provider is likely to question the initial diagnosis for a significant period of time. Latent illnesses may be either: (1) chronic conditions, such as diabetes or high blood pressure, that incrementally damage the body over years or decades, or (2) acute conditions that, if untreated, almost certainly lead to significant impairment or death within a predictable period of time. Susan S. Septimus, *The Concept of Continuous Tort as Applied to Medical Malpractice: Sleeping Beauty for Plaintiff, Slumbering Beast for Defendant*, 22 TORT & INS. L.J. 71, 78 n.41 (1986). Within this Article, "latent illness" refers only to acute conditions (although negligence and/or medical error obviously may be factors in the misdiagnosis of both acute and chronic latent illnesses).

5. Colon cancer, for example, has a five-year survival rate of up to 100 percent when patients are properly diagnosed and treated while the disease is still confined to superficial layers of the bowel. PAUL CALABRESI & PHILIP S. SCHEIN, MEDICAL ONCOLOGY 754 tbl.41-5 (2d ed., 1993) (Astler-Coller staging). Once the cancer has metastasized, however, the five-year survival rate drops to only four percent. *Id.* Similarly, melanoma, if identified and excised while still localized and superficial, has a cure rate of almost 100 percent. *Id.* at 550-54 tbls.32-1, 32-2, 32-3. Left untreated, however, the disease usually spreads via the lymphatic system to distant areas of the body. Once metastasized, a patient's chance of surviving for ten years is less than two percent. *Id.* at 551-53.

6. *See id.* at 165, 553-54.

7. Kenyon v. Hammer, 688 P.2d 961, 963 (Ariz. 1984) (error in documentation of new mother's blood Rh factor at first pregnancy resulted in stillbirth of second child five years after error occurred).

8. Maine's current statute of limitations for health care providers and health care practitioners, ME. REV. STAT. ANN., tit. 24, § 2902 (West 2000), reads:

> Actions for professional negligence shall be commenced within 3 years after the cause of action accrues. For the purposes of this section, *a cause of action accrues on the date of the act or omission giving rise to the injury.* Notwithstanding the provisions of Title 14, section 853, relating to minority, actions for professional negligence by a minor shall be commenced within 6 years after the cause of action accrues or within 3 years after the minor reaches the age of majority, whichever first occurs. *This section does not apply where the cause of action is based upon the leaving of a foreign object in the body, in which case the cause of action shall accrue when the plaintiff discovers or reasonably should have discovered the harm.* For the purposes of this section, the term "foreign object" does not include a chemical compound, prosthetic aid or object intentionally implanted or permitted to remain in the patient's body as part of the health care or professional services.

A victim's right to seek monetary damages for negligently inflicted medical injury has been recognized in the United States for over two hundred years.[9] As with other civil actions, however, the government may place reasonable restrictions on this right in order to achieve a societal benefit.[10] A primary means to that end is the statute of limitations. Normally introduced into litigation as an affirmative defense, statutes of limitation define the maximum time period in which an action may be brought or a right enforced.[11]

Maine's statute of limitations for medical malpractice has evolved primarily over the last several decades.[12] The current statute, ME. REV. STAT. ANN. title 24, section 2902, became effective in 1988.[13] Since that time, Maine courts have found the language and history of the statute to foreclose pursuit of medical malpractice claims filed more than three years after the occurrence of the alleged act of negligence, regardless of whether the injury was discoverable.[14] Thus, at the present time, patients in Maine who suffer a latent medical injury that does not become apparent for three years or more are divested of their legal right to seek

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> If the provision in this section reducing the time allowed for a minor to bring a claim is found to be void or otherwise invalidated by a court of proper jurisdiction, then the statute of limitations for professional negligence shall be 2 years after the cause of action accrues, except that no claim brought under the 3-year statute may be extinguished by the operation of this paragraph.

Id. (emphasis added). Because the statute, as applied to all but foreign object surgical error plaintiffs, terminates a plaintiff's right to bring an action at a point in time without regard to whether an injury stemming from the act of negligence has manifested, section 2902 is technically a statute of repose. Christopher J. Trombetta, Note, *The Unconstitutionality of Medical Malpractice Statutes of Repose: Judicial Conscience Versus Legislative Will*, 34 VILL. L. REV. 397, 401 (1989). For ease of discussion, this Article will refer to both statutes of limitation and statutes of repose as statutes of limitation.

9. *See* Cross v. Guthrie, 2 Root 90 (Conn. 1794).

10. *See, e.g.*, COMMISSION TO EXAMINE TORT LITIGATION AND LIABILITY INSURANCE IN MAINE, INSURING JUSTICE 82 (1987) [hereinafter INSURING JUSTICE] ("Change in tort law should only occur if a . . . social benefit exists which justifies altering laws which have [been] fundamentally fair and just in balancing society's conflicts.").

11. BLACK'S LAW DICTIONARY 1422 (7th ed. 1990). *See generally, Developments in the Law—Statutes of Limitations*, 63 HARV. L. REV. 1177, 1186-90 (1949-50) [hereinafter *Developments*] (discussing the nature and construction of statutes of limitation).

12. Medical malpractice claims in Maine were originally governed by the statute of limitations applicable to the general law, including actions of assumpsit, contract, liability, and "all other actions on the case except for slanderous words and for libel, if not commenced within six years after the cause of action accrued." Miller v. Fallon, 134 Me. 145, 147, 183 A. 416, 416 (1936) (citing R.S. ch. 95, § 90 (1930)). In 1931, the Legislature added medical malpractice to a class of intentional tort actions for which a two-year post-accrual limitation period was applied. R.S. ch. 95, § 92 (1931). This provision was later recodified without change. P.L. 1963, ch. 402, § 170 (codified as ME. REV. STAT. ANN. tit. 14, § 753 (West 1964)). In 1977, the Legislature enacted a two-year statute of limitations applicable to tort claims against hospitals and their employees. P.L. 1977, ch. 492, § 3 (codified as ME. REV. STAT. ANN. tit. 24, § 2092 (West Supp. 1977)), *amended by* P.L. 1985, ch. 804, § 22. Actions against individual physicians at that time continued to be governed by 14 M.R.S.A. section 753. ME. REV. STAT. ANN. tit. 14, § 753 (West 1980). The length of the statutory period for medical malpractice actions remained unchanged until the statute was amended to its present form, increasing the period to three years. P.L. 1985, ch. 804, § 22 (effective Aug. 1, 1988) (defining accrual as the time of the act or omission giving rise to the injury).

13. P.L. 1985, ch. 804, §§ 13, 22.

14. Choroszy v. Tso, 647 A.2d 803, 807 (Me. 1994); *see also* Dasha v. Maine Med. Ctr., 665 A.2d 993 (Me. 1995).

compensation before they can know the right (or injury) exists.

Latent error malpractice actions are, admittedly, few in number. Nonetheless, they are worth examining for two reasons. First, misdiagnosis of the types of diseases involved often leads to injuries that are financially, physically, and, at times, mentally devastating, making victims of latent medical errors among the most vulnerable of plaintiffs. To be rational, therefore, a law denying them the right to pursue their claims should serve a collective need that outweighs not only the profound individual interests possessed by these plaintiffs but also society's interest in protecting citizens who are no longer able to protect themselves. Second, where individuals' legal rights are arbitrarily extinguished in order to secure a benefit for society, it should be capable of demonstration that the deprivation of rights actually helps achieve that benefit.

Section 2902 and numerous other medical malpractice reform provisions[15] were passed in response to a perceived "crisis" in health care. According to many commentators at the time, this crisis was the result of a marked increase in the number of medical malpractice claim filings and in the size of settlements and jury awards.[16] If not dealt with, they warned, the financial burdens of litigation, including rising malpractice insurance premiums, would inflate the costs of medical services and ultimately drive some physicians out of practice altogether.[17] As a result, consumers would be left without access to safe and necessary care.[18]

Maine's legislative record echoes these concerns and makes clear that ensuring the availability of safe and affordable health services was the benefit to society intended by passage of section 2902.[19] Unfortunately, in the years following enactment, section 2902 has been ineffectual in this effort. Health care costs have continued to rise exponentially.[20] Even worse, to the extent that the present statute

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15. For a listing of medical malpractice reforms enacted by the Maine Legislature, *see infra* Part III.B notes 98-101, 105 and accompanying text.

16. *See infra* Part III.A.

17. *See infra* Part III.A.

18. *See infra* Part III.A.

19. *See* 2 Legis. Rec. 1173 (1986) (statement of Rep. Scarpino) ("It is important that the people of the state of Maine have access to proper medical care . . . ."); 2 Legis. Rec. 1163, 1165 (1986) (statement of Sen. Twitchell) ("The malpractice prices threaten rural health care in [Maine]."); *see also* 2 Legis. Rec. 1468 (1986) (statement of Rep. MacBride); 2 Legis. Rec. 1491 (1986) (statement of Sen. Baldacci).

20. *See* KANT PATEL & MARK E. RUSHEFSKY, HEALTH CARE POLITICS AND POLICY IN AMERICA 129 (1995). According to Patel and Rushefsky: "Health care is the largest single industry in the country." *Id.* at 1. "[N]ational health care expenditures increased from $27.1 billion in 1960 to $74.3 billion in 1970 and to $251.1 billion in 1980. By 1993, . . . expenditures had jumped to $884.2 billion." *Id.* at 129; *see also id.* at 130 tbl.6.1., 131 tbl.6.2 (listing percentages of 1993 health costs by type). According to the White House Domestic Policy Council, "[b]etween 1980 and 1992, American health care spending rose from 9 percent of Gross Domestic Product (GDP) to 14 percent. . . . [S]pending on health care will reach 19 percent of GDP by the year 2000." THE WHITE HOUSE DOMESTIC POLICY COUNCIL, HEALTH SECURITY 7 (1993) [hereinafter HEALTH SECURITY].

Patel and Rushefsky identify medical technology as the leading cause of health care cost inflation:

> [In America] access to the latest medical technology is viewed as a right.
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> . . . .
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> Many economists argue that new health care technology is the largest factor driving up . . . costs in the United States. They believe that technology accounts for as

of limitations stifles worthy claims, it may actually diminish patient safety by increasing the likelihood that the medical errors implicated will not be addressed, allowing similar types of injuries to recur in the future.[21]

The failure of section 2902 to contribute to Maine's health care system as intended can be linked directly to misperceptions regarding the causes of the health care crisis that were pervasive when the measure was enacted. According to legislators debating the issue, the crisis was primarily the result of two factors: a more litigious population and the 'inherent risks' of practicing medicine. This assessment, however, was incomplete. It gave little, if any, consideration to the role of other significant occurrences during the years preceding the crisis, including: (1) greater utilization of health care services in general,[22] (2) increasing reliance upon complex medical technologies and delivery systems,[23] and (3) the rapid escalation of error-related patient injuries that coincided with both of these.[24] Because these important causative factors were not considered, legislators implemented provisions, including the current statute of limitations, that target only the consequences of medical error and injury, not the prevention of error itself. As a result, health

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> much as 50 percent of the growth in health care cost beyond overall inflation. . . . [M]edical technologies that did not exist twenty to thirty years ago account for most of the rise in health care spending in the United States. . . .
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> The hospital is the major center of high-tech medicine, and hospital care constitutes the single largest component of our health care spending, about 40 percent. The most important factor stimulating hospital cost increases is the rapid adoption of new medical technology, according to a report by the General Accounting Office. Competition among hospitals combined with a third-party reimbursement system provides incentives for rapid advancement of medical technologies in hospitals. Since hospitals do not compete for patients on the basis of price, hospitals try to gain market advantage by offering the most up-to-date services, and the cost of these technologies is passed on to the third-party payers—insurance companies.

PATEL AND RUSHEFSKY, *supra*, at 165, 167 (citing GENERAL ACCOUNTING OFFICE, HOSPITAL COSTS: ADOPTION OF TECHNOLOGIES DRIVES COST GROWTH 2).

Analyst Eli Ginzberg also cites the lack of market constraints (caused by third-party payers and medical entitlement programs) on physicians and hospitals to "control the volume of services they provide" or the introduction of new technologies. ELI GINZBERG, THE ROAD TO REFORM 129 (1994). According to Ginzberg: "Looking at the dynamics of the health care market in retrospect, the wonder is not that the total health care outlays increased fourfold since mid-1960s [through 1992] but that, in the absence of governmental and market controls, the increases were not even greater." *Id.* Fraud, waste, and inefficiency within the health care system, such as the lack of emphasis on preventative medicine, are also cited as contributing to health care cost inflation. HEALTH SECURITY, *supra,* at 10, 50 ("In the last decade, the number of health administrators grew 16 times as fast as the number of doctors.").

21. *See generally* Orentlicher, *supra* note 1.

22. *See* PATEL & RUSHEFSKY, *supra* note 20, at 36 (Medicare and Medicaid programs resulted in increased health care consumption by elderly and disabled); *see also* GINZBERG, *supra* note 20, at 146 ("Approximately 1.5 billion transactions take place every year between patients and physicians.").

23. *See* Neville M. Bilimoria, *New Medicine for Medical Malpractice: The Empirical Truth About Legislative Initiatives for Medical Malpractice Reform-Part II*, 27 J. HEALTH & HOSP. L. 306 (1994) ("the crisis was propelled by the increases in technology over the years, not by the tort system").

24. *See* Robert H. Brook et al., *The Relationship Between Medical Malpractice and Quality of Care,* 1975 DUKE L.J. 1197, 1209 ("modern medicine has increased the physician's chance of doing harm, and the probabilistic nature of medical treatment alone would suggest that malpractice claims would dramatically increase").

care in Maine has subsequently become neither safer nor more affordable.

Medical errors are the eighth leading cause of death in the United States.[25] In addition to the human toll, preventable medical errors result in economic losses of between $17 billion and $29 billion annually, half of which occur as health care expenses.[26] Recognition of the true nature and magnitude of this problem and understanding how it contributes to medical injuries, litigation, and health care cost inflation are prerequisite to reducing these negative consequences and optimizing the safety and affordability of health services in Maine. Concurrently, however, it should be acknowledged that innocent individuals suffer injury as a result of medical negligence and error. Maine's health care policy need not and should not irrationally deny these victims their right to a remedy.

This Comment examines Maine's statute of limitations for medical malpractice within the context of tort and health care reform. Specifically, this Comment addresses the efficacy of legislation fixing accrual at the time of the negligent act, thus precluding courts from applying a "discovery rule" to actions in which injury becomes apparent only after the statute has run. Discussion of the statute of limitations propels an examination of factors contributing to the high frequency of medical malpractice claims, and the need to change current procedures within both the medical and legal systems that disserve the public interest.

Part II of this Comment presents a synopsis of medical and legal developments that laid the foundation for our present system of medical malpractice resolution. Part III discusses the medical malpractice "crisis" of the 1970s and 1980s: the increases in both claim frequency and the size of damage awards, and the effect of these and other factors on medical malpractice insurance. Empirical data from three studies evaluating rates of negligent occurrences and claims filed is also included in this discussion.

Part IV examines the enactment of section 2902: the history of statutes of limitation generally, and the history of the Maine Legislature's enactment of the current statute as well as other reform provisions in the Maine Health Security Act. Part V looks at the constitutionality of section 2902 through a brief presentation and analysis of two court challenges to the statute. Part VI examines section 2902's contribution to the Legislature's goal of ensuring access to safe and necessary care for Maine's citizens. Part VI also discusses current theory and initiatives addressing the problem of medical error and injury in health care.

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25. INSTITUTE OF MEDICINE, *supra* note 1, at 1. Between 1980 and 1992, three major studies estimating the number of deaths each year attributable to medical errors have produced inconsistent figures. The variations may be due in part to geographic differences between the studied areas (California, 1980; New York, 1985; and Utah-Colorado, 1992), improvements in care systems over time, as well as empirical inaccuracies. *See* Orentlicher, *supra* note 1, at 247-48. Despite the variations in mortality rates, all of the studies concluded that medical error is a major cause of injury and death in the United States. *Id.* at 248.

26. INSTITUTE OF MEDICINE, *supra* note 1, at 1, 34. These figures, drawn from the Utah-Colorado study, are based on data collected in 1992. *Id.* at 34. Further, they represent only preventable patient injuries. *Id.* The study's authors estimated that "the national costs of adverse events [suffered by hospitalized patients were] $37.6 billion . . . [or] approximately 4 percent of national health expenditures in 1996." *Id.* These figures address only the cost of medical errors occurring in hospitals, and thus likely grossly underestimates the scope of the problem. Costs resulting from outpatient medication errors alone have been estimated to be $76.6 billion per year. *Id.* at 35 (citing Jeffery A. Johnson and J. Lyle Bootman, *Drug-Related Morbidity and Mortality: A Cost-of-Illness Model*, 18 ARCHIVES OF INTERNAL MED. 1949 (1995)).

In Part VII, this Comment argues that: (1) persons who are injured by preventable medical error and diligently pursue their claim have the right to seek redress through the legal system; (2) this right is subject to reasonable governmental restrictions instituted to further a legitimate state interest; (3) the legitimate interests to which section 2902 was directed were ensuring safe, quality health care for Maine's citizens; and (4) the present occurrence-based statute of limitations for medical malpractice does not contribute to these interests and may, in fact, negatively impact the quality of health care in Maine by discouraging reporting of medical errors and the implementation of error prevention procedures.

Finally, this Comment recommends that 24 M.R.S.A. section 2902 be amended to allow application of discovery-based accrual where the injury at issue was inherently undiscoverable within the statutory period. This Comment further recommends that Maine develop a rational, comprehensive policy aimed at promoting safe and affordable health care by reducing the occurrence of preventable medical error, injury, death, and the resulting litigation.

II. A BRIEF HISTORY OF MEDICAL MALPRACTICE LITIGATION

Prior to the 1970s, medical malpractice litigation went almost unnoticed by the government and the public at large. Such claims, however, were litigated in the United States as early as the 1794 case of *Cross v. Gunthrie*.[27] *Cross* and other early cases were tried under principles of medical jurisprudence largely derived from English malpractice common law.[28] But even these early cases do not provide the true origins. The concepts of deterrence and compensation, the starting point from which malpractice law proceeds,[29] arose thousands of years before, in the codes of ancient civilizations.[30]

Perhaps the earliest malpractice resolution system was developed by the Sumerians who, in about 4050 B.C., addressed deterrence and compensation objectives dually by requiring negligent healers to pay their victims an amount of money proportional to the degree of disability incurred.[31] Later codes, including the 3750 B.C. code of Babylonian King Hammurabi, stressed deterrence over compensation.[32] According to the applicable law of the day, "if a physician operate on

27. 2 Root 90 (Conn. 1794).

28. *See* IAIN HAY, MONEY, MEDICINE AND MALPRACTICE IN AMERICAN SOCIETY 5 (1992).

29. Edward A. Dauer, *When the Law Gets in the Way: The Dissonant Link of Deterrence and Compensation in the Law of Medical Malpractice,* 28 CAP. U. L. REV. 293, 295 (2000). Professor Dauer summarizes these two objectives of malpractice law as follows:

> When the patient-now-plaintiff receives an amount of money that is dictated by . . . the amount of his or her loss, the patient is restored to as good a position as if the negligent act had not occurred. . . . This is the compensatory function of the law of torts.
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> At the same time, . . . by requiring that the money the plaintiff receives be paid by or on behalf of the negligent defendant, similarly situated doctors will be made aware of the fact that similar negligent acts will result in mandatory payments [and] will be encouraged . . . to guard against committing . . . similar negligent act[s].

Id.; *see also* Randall Bovbjerg and Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence,* 67 U. CIN. L. REV. 55, 57 (1998) [hereinafter Bovbjerg, *No-Fault*] (stating that the three primary goals of the personal injury tort-liability system are "compensation, deterrence, and justice").

30. HAY, *supra* note 28, at 3-5.

31. *Id.* at 3-4.

32. HAY, *supra* note 28, at 5; *see also* FIELDING H. GARRISON, HISTORY OF MEDICINE 62 (1989).

a man and cause the man's death . . . they shall cut off [the physician's] fingers."[33] This emphasis on deterrence was also present in ancient Egypt, where negligent practioners were subject to an even more severe sanction: the death penalty.[34]

The evolution of malpractice law continued in medieval Europe. During that period, advances in science and medicine were all but curtailed.[35] In many areas the practice of medicine was considered the work of menials and left to odd segments of the population including magicians and "wolf-men" who relied upon medicinal herbs, charms, and spells.[36] Not surprisingly, poor outcomes were all too common and, out of necessity, medical malpractice laws retained a strong emphasis on deterrence. In medieval Spain, for example, patient injury and death secondary to excessive bloodletting was such a problem that laws were enacted authorizing the relations of deceased victims to deal with the phlebotomists in whatever manner they chose.[37]

As Europe moved toward the Renaissance, development and refinement of malpractice doctrines continued. In 1374, another important principle, the physician's duty of care was laid out by Justice John Cavendish.[38] According to Justice Cavendish, the doctor was required to utilize his or her professional skills and to apply his or her best efforts in attempting to effectuate a cure.[39]

The English malpractice doctrines traveled to the colonies, serving as the basis for American malpractice jurisprudence until the middle of the nineteenth century when a substantial body of domestic case law began to accumulate.[40] Prior to 1858, the number of malpractice actions in this country was negligible.[41] This was due in part to the fact that the country was predominantly rural, as well as the generally low expectations regarding the benefits that medical care could provide.[42] Over the next fifty years, however, courts began to hear increasing numbers of cases.[43] This rise in the frequency of malpractice actions coincided with funda-

33. HAY, *supra* note 28, at 3.

34. *Id.* at 4; *see also* GARRISON, *supra* note 32, at 57. Like physicians during the Hammurabian period, by the 5th century B.C. medical practitioners in Egypt were highly specialized and regulated by the government. *Id.* Doctors were expected to follow approved practice guidelines and if a deviation caused the death of a patient, "it was regarded as a capital crime." *Id.*

35. GARRISON, *supra* note 32, at 140-41. After the fall of Rome, civilizations in Europe fell into social chaos. *Id.* at 140-41. As a result, "the greatest need . . . of humanity was for spiritual uplift . . . rather than for intellectual development." *Id.* at 140. As authority over almost all aspects of life was surrendered to the Church, health care was transformed into "[m]onastic medicine" that relied upon "faith healing, . . . and belief in the miraculous healing power of the saints and of holy relics." *Id.* at 145.

36. *Id.* at 169-70.

37. HAY, *supra* note 28, at 4-5. Medical care in medieval Spain was otherwise subject to a money back guarantee. *Id.* at 4; *see also* E. F. Frey, *Medicolegal History: A Review of Significant Publications and Educational Developments*, 10 LAW, MED. & HEALTH 56, 56-60 (1982).

38. Y.B. Hill. 48 Edw. III, f. 6 (1374).

39. *Id.*

40. HAY, *supra* note 28 at 8. Notable early nineteenth century cases retained and expanded upon the common law doctrines regarding a physician's duty of care, holding that duty to include possession of a reasonable degree of skill and education, to use due diligence, and to stay abreast of current medical developments. *See* Leighton v. Sargent, 27 N.H. 460 (1853); Pike v. Honsiger, 49 N.E. 760 (N.Y. 1898).

41. HAY, *supra* note 28, at 7-9.

42. *Id.* at 7 (quoting Voltaire's statement that Nineteenth Century medicine "involved little more than 'amusing the patient while nature cures the disease'").

43. HAY, *supra* note 28, at 8.

mental changes occurring in the medical field that dramatically altered public perceptions and expectations regarding health care.

For the first one hundred and twenty-five years of our nation's history, the practice of medicine, as it had been for thousands of years, was primarily palliative.[44] By the end of the nineteenth century, however, three discoveries had occurred that would soon revolutionize health care. First, in 1846, ether became available as a relatively safe and effective anesthetic agent.[45] Next was Wilhelm Roentgen's discovery of the x-ray in 1895.[46] Finally, and even more significant than ether or x-ray imaging, was the work of Joseph Lister. In 1867, Lister announced his discovery of reliable means to prevent the spread of many infections related to surgery.[47] By 1880, aseptic techniques, including hand washing and other simple measures, were widely adopted by caregivers to prevent the spread of disease.[48] By 1900, aseptic practices used in combination with the other advances of the previous century opened the door for development of more invasive and complex diagnostic and surgical techniques.[49]

In addition to improvements in surgical care, the work of Lister and his predecessors also spurred research that ultimately led to the discovery of penicillin and widespread use of antibiotics to combat infectious disease.[50] The development of vaccines soon followed.[51] The effect of these therapies on the death rates for young children was phenomenal. By 1950, the infant mortality rate in the United States was less than 15 per 100,000 live births, down from approximately 300 infant deaths per 100,000 births in 1900.[52] The benefits of these innovations were not limited to children; antibiotics and vaccines also played a significant role in extending the lives of the adults, particularly the elderly.[53]

Success against infectious disease was followed by a wave of research pro-

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44. ROBERT RHODES, HEALTH CARE POLITICS, POLICY AND DISTRIBUTIVE JUSTICE: THE IRONIC TRIUMPH 7-10 (1992).

45. *See id.* at 11.

46. *See* JEAN STAROBINSKI, 12 A HISTORY OF MEDICINE 85 (Bernard C. Swift trans., 1964).

47. *See* RHODES, *supra* note 44, at 11-12. The discovery of a definitive link between microorganisms and certain diseases is credited to Robert Koch, a German physician who in 1882 demonstrated that specific germs isolated and reproduced in a laboratory would give rise to specific infectious diseases. *See* SIR WILLIAM OSLER, THE EVOLUTION OF MODERN MEDICINE 211-12 (reprint 1972) (1921). Koch's work was expanded by Louis Pasteur's research on fermentation and conditions favorable to infection. *Id.* Lister's experiments applied Pasteur's findings to the prevention of infection in surgical wounds.

48. *See* RHODES, *supra* note 44, at 12.

49. *Id.* Shortly after 1900, the more reliable means of diagnosis, anesthesia, and control of infectious disease made possible by these discoveries allowed surgeons to begin developing complex techniques that led to modernsurgical practices. *Id.*

50. *Id.*; *see also* PATEL & RUSHEFSKY, *supra* note 20, at 31-32.

51. RHODES, *supra* note 44, at 13. The theory behind the development of vaccines can be traced to the work of English physician Edward Jenner who in 1798 observed that a common and benign infection, cow pox, produced immunity to the much more serious disease of small pox. OSLER, *supra* note, at 198-200.

52. RHODES, *supra* note 44, at 12.

53. *See id.* at 11-12. In addition to dramatic medical advances, life style improvements such as improved diet, increased income, and improved education also significantly contributed to increased health and life expectancies for Americans during the first half of the twentieth century. *Id.*

ducing an exponential expansion of medical technology.[54] As the fruits of these efforts became commonly available, diagnosis and treatment of almost all diseases was dramatically improved.[55] Additionally, during the 1960s, government Medicaid and Medicare programs helped make cutting-edge health care an affordable reality for record numbers of Americans.[56] Not suprisingly, these "medical miracles" fundamentally changed perceptions of health care. The previous general acceptance by people of disease and death as normal life occurrences was replaced by expectations of good health and longevity. Patients no longer looked to their doctors primarily for care—they expected a cure.[57]

By 1970, with increasingly effective treatments for serious diseases available and accessible, the pressure on practitioners to make early and accurate diagnoses was intense. Further, while advanced treatments could be highly beneficial, their complexity often made them difficult to administer and monitor. As a result, serious iatrogenic complications began to occur with ever more frequency. The opportunity for medical error by omission or commission was greater than ever before.[58]

III. THE MEDICAL MALPRACTICE "CRISIS"

A. The Nature of the "Crisis"

In 1950, medical malpractice claims remained few in number,[59] and many physicians did not feel compelled to carry malpractice insurance.[60] By 1970, however, malpractice coverage was a professional necessity.[61] Physicians considered their financial security to be as dependent upon liability insurance as it was on income generated from their practice.[62] Such was the mind-set within the medical community when a medical malpractice "crisis" arose in the early 1970s,[63] to be followed by a second crisis in the mid-1980s. These crises were in large part reactions to two concurrent developments: the rising incidence of malpractice litigation and the increase in medical malpractice insurance premiums.[64] Although

54. *See* PATEL & RUSHEFSKY, *supra* note 20, at 33-34, 161. Bio-medical research became a national priority in 1945, with increased government funding and a related emphasis on research in medical education. *Id.* at 161-62.

55. *Id.* at 159-61.

56. *Id.* at 34-37.

57. RHODES, *supra* note 44, at 14.

58. *E.g.*, PATEL & RUSHEFSKY, *supra* note 20, at 13; Paul C. Weiler et al., *Proposal for Medical Liability Reform*, 267 J. AM. MED. ASS'N 2355, 2355 (1992) [hereinafter Weiler, *Proposal*].

59. *See* Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. DAVIS L. REV. 499, 501 (1989) [hereinafter Bovbjerg, *Legislation*].

60. *See* HAY, *supra* note 28, at 77.

61. *Id.* at 86; *see also* Brook et al., *supra* note 24, at 1197.

62. *See* HAY, *supra* note 28, at 77.

63. *See* Bovbjerg, Legislation, *supra* note 64, at 500 n.1 (casting doubt on the extent and overall social importance of events surrounding the "crisis").

64. *Id.* at 500-01; *see also* PUBLIC HEALTH RESOURCE GROUP, INC., FINAL REPORT: MEDICAL MALPRACTICE LIABILITY STUDY (1989) [hereinafter LIABILITY STUDY]. According to the report's authors, "[m]any . . . factors, such as the distribution of illness, physicians' capabilities, biotechnology, peer review and risk management programs, litigation strategy, public attitudes towards risk and compensation, and insurance rate-making procedures, all may contribute to the number of claims filed, their outcome, and the price of insurance." *Id.* at 6.

many physicians and policy-makers argued at the time that the former produced the latter,[65] the degree to which malpractice litigation actually precipitated insurance rate hikes has not been definitively quantified.[66] It is well documented, however, that by 1970 both the number of medical malpractice claims filed (frequency) and the size of resultant settlements and verdicts (severity)[67] had risen substantially.[68]

In 1950, physicians had only a one in seven chance of being sued throughout their entire career.[69] By 1960, this chance had increased to 1 claim per 100 doctors annually.[70] In the mid-1980s, this figure was at 17 claims per 100 doctors.[71] Similarly proportioned trends also occurred in claim severity.[72] A study by the Rand Civil Justice Project on jury verdicts in malpractice litigation found that in Chicago the average jury verdict rose from $50,000 in 1960 to $1,200,000 in the early eighties.[73] The study noted consistent figures for malpractice awards in San

65. *See* David Randolph Smith, *Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws*, 38 OKLA. L. REV. 195, 196-97 & n.4 (1985).

66. *See* Bovbjerg, *Legislation*, *supra* note 59, at 510-11 (noting that no one really knows why increases or decreases in malpractice claim filings occur); *see also* HAY, *supra* note 28 at 109 n.1 (noting that accurate national medical malpractice claim data is almost impossible to obtain). At least one researcher has linked the increase in claim frequency that began in the 1970s to social factors, the degree of urbanization and the number of physicians per capita, as well as plaintiff friendly tort laws in place at the beginning of the decade. *See* PATRICIA M. DANZON, THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS 64-65 (1982) [hereinafter DANZON, FREQUENCY]. Interestingly, Danzon found that the number of lawyers per capita did not correlate with any increase in the number of claims filed. *Id.* at 36.

67. Averages of claim severity are determined by comparing the total amount of compensation paid by insurers for medical malpractice claims against the average amount paid per claim. REPORT OF THE TASK FORCE ON MEDICAL LIABILITY AND MALPRACTICE, DEPARTMENT OF HEALTH & HUMAN SERVICES 166 (August, 1987) [hereinafter REPORT OF THE TASK FORCE].

68. *See* Patricia Munch Danzon & Lee A. Lillard, *The Resolution of Medical Malpractice Claims: Research Results and Policy Implications*, 1982 THE INSTITUTE FOR CIVIL JUSTICE V; *see also* Brook et al., *supra* note 24, at 1197-98; H.R. REP. No. 101-26, ch. 2 at 7 (1990) (noting that claim severity and frequency vary significantly by location and specialty of practice).

69. Bovbjerg, *Legislation*, *supra* note 59, at 501.

70. PAUL C. WEILER, MEDICAL MALPRACTICE ON TRIAL 2 (1991) [hereinafter WEILER, MEDICAL MALPRACTICE].

71. *Id.*; *see also* DANZON, FREQUENCY, *supra* note 66, at 4-5; Randall R. Bovbjerg & Kenneth R. Petronis, *The Relationship Between Physicians' Malpractice Claims History and Later Claims*, 272 J. AM. MED. ASS'N 1421 (1994). Bovbjerg and Petronis reviewed 1984 General Accounting Office (GAO) data. According to the GAO, in 1984, there were 53,251 claims filed with malpractice insurers. These claims produced 2766 verdicts, approximately 553 of which were for plaintiffs. Of 1040 appeals, only 477 resulted in any payment to plaintiffs. *Id.* Toward the end of the 1980s, statistics gathered by the American Medical Association's Socioeconomic Monitoring System indicated that claim frequency had leveled and even decreased (although data collection methods changed in 1985, making a direct comparison of figures from before and after that date slightly less accurate). *Id.* According to their figures, the claims rate dropped at an average annual rate of 14.4 percent between 1985 and 1988. *See* H.R. REP. No. 101-26, ch. 2, at 12.

72. Bovbjerg, *Legislation*, *supra* note 59, at 501-02.

73. WEILER, MEDICAL MALPRACTICE, *supra* note 70, at 3 (citing MARK PETERSON, CIVIL JURIES IN THE 1980S, RAND, THE INSTITUTE FOR CIVIL JUSTICE 20-25 (1987)).

Francisco during the same period.[74]

It is undisputed as well that by the early 1970s doctors in many areas of the country began to experience significant increases in their malpractice premiums.[75] Even more alarming, malpractice carriers began to leave the market.[76] Physicians reacted quickly and vocally, generally blaming the insurance problems on the rising number of lawsuits and juries handing out large awards.[77] According to the doctors, they were being driven out of practice by the cost of liability insurance.[78]

In contrast to physicians' assessment of the problem, others argued that additional factors contributed to the rise in medical malpractice insurance rates and the insolvency of certain carriers. They pointed to insurer pricing practices,[79] and

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74. *Id.*; *see also* DANZON, FREQUENCY, *supra* note 66. Danzon's data also demonstrated a steady upward trend in claim severity during the 1970s. *Id.* at 6-7; *see also* H.R. REP. No. 101-26 ch. 2, at 11, table 2.1 (1990) (data compiled by the PHYSICIANS AND SURGEONS UPDATE, THE ST. PAUL'S ANNUAL REPORT TO POLICY HOLDERS).

In 1980, the average jury verdict in the United States for medical malpractice was $404,726. *Id.* The total number of verdicts reported for the year was 146. *Id.* There were 20 awards of $1,000,000 or more. *Id.* In 1985, these figures had risen to an average verdict of $1,179,095. *Id.* The total number of verdicts for malpractice plaintiffs was 356, and the number of awards greater than $1,000,000 was 71. *Id.* By 1988, these figures had dropped, with average verdicts for plaintiffs of $732,445, total verdicts for plaintiffs of just 121, and the total number of payouts greater than $1,000,000 was down to 31. *Id.*

However, in 1995, five of the ten largest jury awards in the United States were for medical malpractice. *See* WILLIAM J. CURRAN ET AL., HEALTH CARE LAW AND ETHICS 468 (5th ed. 1998). Other data indicates that the majority of recoveries (usually settlements) by malpractice are relatively modest, and most do not even recover enough to cover costs they have incurred as a result of their injury. In a 1994 study conducted in Florida, known as a plaintiff friendly state, 37 percent of paid medical malpractice claimants received less than $20,000. *Id.* Only 3 percent received $1,000,000 or more. *Id.*

75. Bovbjerg, *Legislation*, *supra* note 59, at 502-03. Premiums paid by physicians tripled during the 1970s, rising from 0.5 percent of gross income in 1962 to 1.8 percent of gross income by the end of the 70s. *Id.* at 502 nn.7-8.

76. *See* HAY *supra*, note 28, at 89. By the fall of 1974, seven states found most commercial carriers of malpractice insurance leaving their markets. *Id.* Between 1967 and 1977, the number of insurers providing medical malpractice coverage nationally dropped from 100 to fewer than 12. *Id.* It is not clear from the data, however, whether the majority of states experienced availability problems. *Id.* Prior to the crisis, most states did not maintain records on malpractice insurance operations. *See* Bovbjerg, *Legislation*, *supra* note 59, at 504 n.24. In contrast to the 1970s malpractice insurance situation, the crisis of the 1980s was primarily one of affordability, not availability. *See* LIABILITY STUDY, *supra* note 64, at 20; Bovbjerg, *No-Fault*, *supra* note 29, at 61. Bovbjerg concludes that the insurance crisis of the 1980s was due in part to two separate insurance-related phenomena—malpractice insurers continuing to raise premiums, and health care insurers limiting reimbursement. *Id.* As a result, physicians were now forced to absorb at least part of malpractice premium increases. *Id.*

77. *See* HAY, *supra* note 28, at 107; Bovbjerg, *Legislation*, *supra* note 59, at 506-07.

78. *See* WEILER, MEDICAL MALPRACTICE, *supra* note 70, at 27.

79. *See* Thomas P. Hagen, Note, *"This May Sting A Little"—A Solution to the Medical Malpractice Crisis Requires Insurers, Doctors, Patients, and Lawyers to Take Their Medicine*, 26 SUFFOLK U. L. REV. 147, 166-68 (1992) (discussing insurers' alleged excessive profit taking and mismanagement as contributing to the crisis) (citing Tony Cunningham & Robin Lane, *Malpractice—The Illusory Crisis*, 54 FLA. B.J. 114, 116 (Feb. 1980)). For a more detailed explanation of how medical malpractice premiums are set, see LIABILITY STUDY, *supra* note 64, at 53-59. In brief, medical malpractice premiums are used to fund commercial insurers' operational expenditures, provide a profit, and pay costs associated with claims filed against policyholders. *See id.* Utilizing data from previous years, insurers estimate their future claims costs and set

related insurance cycles.[80] In addition, many observers implicated decreased returns from insurers' portfolios. These analysts argued that sagging investment profits during the economic recessions of the 1970s and mid-1980s caused insurers to increase premiums in order to make up for disappointing returns.[81] They claimed an extremely competitive insurance market compounded the effect of the increase in filings in the late 1960s and early 1970s, leading many insurers to under-price policies where they believed other investment income would make up the difference.[82]

Although it is less than clear exactly what factors, and in what proportion, led to the rapid rise in physicians' medical malpractice premiums during the 1970s and 1980s, the resultant demand by doctors and insurers for relief from the crisis was unmistakable.[83] Led by the American Medical Association (AMA),[84] physicians warned that unless decisive action was taken, the nation's health delivery system would be in peril.[85] The AMA forcefully called for changes to the rules governing medical malpractice litigation, and state legislatures responded.[86]

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present premiums accordingly. Because these funds are collected in the present to be paid out in the future, in the near term insurers may invest the money and create a supplemental source of income. *Id.* at 54. Insurers use of investment income to increase profits or alternatively decrease malpractice premiums produces the insurance "cycle" effect. *Id.* at 53-54.

80. WEILER, MEDICAL MALPRACTICE, *supra* note 70, at 8. Insurance cycles have historically involved several stages. First, insurers rely on "capacity" or capital derived from premiums and reserves (cash on hand kept out of investment in order to cover estimated claims payouts that will occur in the near future) in determining what "risks" to accept. REPORT OF THE TASK FORCE *supra* note 66, at 158. When overall capacity is limited, premiums are increased to generate more capital. *See id.* Profits then improve, and more insurers are attracted to the industry, bringing with them more capital and thus more capacity to bear risk (underwrite claims). *Id.* After a time, supply of insurance exceeds demand. *Id.* As the market becomes more competitive, premium prices drop. *Id.* Eventually, profits also drop and insurers leave the market. *Id.* The overall capacity of the industry to bear risk (underwrite claims) is then reduced. *See id.*

81. WEILER, MEDICAL MALPRACTICE, *supra* note 70, at 8-9 (noting that interest rate sensitive bonds are a mainstay of insurers investment portfolios). *But see* Sean F. Mooney, *The Liability Crisis—A Perspective,* 32 VILL. L. REV. 1235, 1246 (1987) (arguing that the data does not support the assertion that insurers unsuccessfully bet on continued high interest rates and subsequently acted to make up for lost investment income by increasing malpractice premiums).

82. HAY, *supra* note 28, at 92-93. Hay notes:

> Premium price competition of the 1970s was so severe and investment opportunities so attractive that it was necessary for most liability insurers to engage in a practice known as "cash-flow underwriting." That is, income received in the form of premiums was actually anticipated to be insufficient to cover future claims. Spurred on by competition, companies were obliged to put their faith in the possibility that investment returns would compensate for underwriting losses. So fierce and compelling was the competition for premium dollars that medical liability policy costs continued to be held at low rates despite growing claims pressure and other evidence insurers may have had a prospective of peril.

Id.

83. *See id.* at 106-07.

84. The AMA, then and now, advocates forcefully for physicians' interests at a state and federal level. PATEL & RUSHEFSKY, *supra* note 20, at 21. According to Patel and Rushefsky, the AMA finances one of the nation's largest political action committees. *Id.* Between 1991 and 1992, "the American Medical Political Action Committee . . . spent $2.3 million on contributions to congressional candidates, with another $1 million in 'independent expenditures.'" *Id.*

85. HAY, *supra* note 28, at 103.

86. Bovbjerg, *Legislation, supra* note 59, at 511.

B. Malpractice Litigation Reform

By the end of the 1970s, every state had enacted some form of legislation aimed at alleviating the medical malpractice crisis.[87] This burst of activity was followed by a second wave of legislative action in the mid-1980s when, after leveling for a number of years, malpractice premiums once again began to rise.[88] State legislative provisions enacted were generally of three types: (1) malpractice insurance regulation,[89] (2) measures addressing physician competency,[90] and (3) malpractice litigation reforms.[91]

Throughout the 1970s and 1980s, state legislatures passed a variety of medical malpractice "tort reforms." Almost all were designed to shift the burden of litigating a medical malpractice claim in order to make it more difficult for plaintiffs to prevail. These provisions may be categorized as follows:

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87. *Id.; see also* HAY, *supra* note 28, at 103-04 (noting that, with the exception of Wisconsin, all state legislatures passing medical malpractice measures in 1975 defined the problem as strictly one of insurance availability).

88. Bovbjerg, *Legislation*, *supra* note 59, at 532.

89. *Id.* at 514-17, 533-35. Most states created Joint Underwriting Associations (JUAs) during the 1970s, primarily to address concerns about decreased availability of coverage. *Id.* at 514. The associations generally consisted of a pool of the state's malpractice carriers, and business practices were conducted centrally. *Id.* In addition to stability from centralized management, the legislatures guaranteed the solvency of JUAs, which insured that physicians in high-risk specialties would not be denied coverage. *Id.* at 514-15. For almost twenty years, Maine malpractice carriers operated through a legislatively mandated JUA. P.L. 1975, ch. 492, *repealed by* P.L. 1995, ch. 311, § 1. They are presently regulated under 24-A M.R.S.A. sections 2301 to 2328, with section 2304-C specifically regulating the rates insurers may charge for physicians' liability coverage. ME. REV. STAT. ANN. tit. 24-A, §§ 2301-28 (West 2000).

90. *See* Bovbjerg, *Legislation*, *supra* note 59, at 519-21, 535-38. In Maine, current statutory measures intended to insure the competence of individual physicians include 24 M.R.S.A. sections 2501 to 2511 (Professional Competence Reports, enacted in 1977), and sections 2601 to 2608 (Liability Claims Reports, enacted in 1977). ME. REV. STAT. ANN. tit. 24, §§ 2501-11, 2601-08 (West 2000).

Unlike most of Maine's statutory provisions addressing quality of care issues, the mandates of section 2503 are directed toward hospitals, not just the competence of individual physicians. ME. REV. STAT. ANN. tit. 24, § 2503 (West 2000). The statute, in very general terms, requires hospitals to establish procedures for peer review, patient grievance resolution, collection of data regarding "negative health care outcomes" and billing complaints, and programs of professional education. *Id.* The statute does not provide a mechanism for auditing hospitals' compliance with its requirements, or a penalty for non-compliance. *See id.*

In 1989 the Legislature attempted a different approach to the problem of medical malpractice litigation, creating the Medical Liability Demonstration Project. *See* ME. REV. STAT. ANN. tit. 24, §§ 2971-79 (West 2000). Under this scheme, doctors practicing in named high-risk specialty areas may assert their compliance with approved clinical practice guidelines as an affirmative defense in any subsequent litigation. *Id.* § 2975. The program was intended to both improve the quality of medical care and decrease the frequency and severity of claims. A recent evaluation, however, concluded that it has done neither to any measurable degree. *See* MILLIMAN & ROBERTSON, INC., MAINE BUREAU OF INSURANCE, EVALUATION OF MEDICAL MALPRACTICE TORT REFORM: COLLATERAL SOURCE PAYMENT REDUCTION—MAINE DEMONSTRATION PROJECT (October 10, 2000) [hereinafter EVALUATION].

91. Bovbjerg, *Legislation*, *supra* note 59, at 521-33, 538-40. For a summary of legislative measures enacted during the 1970s and 1980s, see *id.* at 513 tbl.1. Because this Comment focuses primarily on the effects of malpractice litigation reforms, and the statute of limitations in particular, statutory provisions enacted in Maine that regulate malpractice insurers and physician competence are given comparatively little discussion.

1. Measures directly decreasing the number of claims filed. These measures included arbitration provisions, limits on plaintiffs' attorneys' fees, pre-litigation screening panels, and restrictions on statutes of limitation and on application of the discovery rule.[92]

2. Provisions limiting the size of damage awards. Ad damnum clause restrictions,[93] caps on non-economic (pain and suffering) damage awards, and the introduction of plaintiffs' collateral sources of compensation into evidence are three commonly employed examples.[94]

3. Measures that make it more difficult for plaintiffs to prevail. Expert witness requirements are used in many states for this purpose.[95]

4. Provisions related to the legal process, such as notice requirements.[96]

The Maine Legislature's initial response to the medical malpractice crisis occurred in 1975. Concerned that some Maine physicians would soon be unable to afford or obtain malpractice coverage, the legislature created the Commission to Revise the Laws Relating to Medical and Hospital Malpractice.[97] Chaired by Justice Charles A. Pomeroy, the commission's mandate was to "insure the availability of medical and hospital malpractice insurance to physicians and hospitals throughout the State and to develop a more equitable system of relief for malpractice claims."[98] After gathering data and conducting several hearings, the Pomeroy Commission submitted its proposals to the legislature.[99] According to the chair, these proposals were intended as:

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92. *Id.* at 522-24. Many states also shortened the tolling period provided for minors to discover an injury. *Id.* at 524. Elimination of discovery-based accrual options for plaintiffs was intended to minimize the "long-tail" effect that insurers complained left them exposed indefinitely to potential liability from past acts. Josephine Herring Hicks, *The Constitutionality of Statutes of Repose: Federalism Reigns,* 38 VAND. L. REV. 627, 633 (1985).

93. An ad damnum clause in a complaint lists the award sought by the plaintiff. Bovbjerg, *Legislation, supra* note 59, at 525.

94. *Id.* at 525-27.

95. *Id.* at 528.

96. *Id.* at 531. Typically, a plaintiff is required to give an intended defendant between thirty and ninety days written notice prior to filing a claim. *Id.* Ideally, parties use this time to attempt settlement. Arbitration is also designed to serve this purpose. *Id.*

97. P. & S.L. 1975, ch. 73.

98. THE COMMISSION TO REVISE THE LAWS RELATING TO MEDICAL AND HOSPITAL MALPRACTICE INSURANCE, REPORT TO THE ONE HUNDRED AND EIGHTH LEGISLATURE i (Jan. 22, 1977) [hereinafter THE POMEROY REPORT] (quoting P. & S.L. 1975, ch. 73, § 1).

99. In addition to its legislative recommendations, the commission made several interesting observations. First, the commission noted that, although it produced a package of specific recommendations aimed at alleviating the problems of rising numbers of malpractice claims and insurance cost inflation, it had done so in an informational void. *See id.* at xix. According to the commission, "there is no data available from which to deduce objectively a single or overriding cause of the crisis. . . . The preponderance of opinion, however, was . . . that the issue is most complex and involves the interaction of general social attitudes and developments within the professions of medicine, law and insurance." *Id.* at xvii.

Next, the commission considered the role played by medical error (though only as it related to individual practitioners). The commission made the judgment that physician incompetence alone could not be responsible for the rise in claim frequency that had occurred over the previous decades, because "health technology and the quality of medical education have advanced markedly in recent decades." *Id.*

> an important first step toward maintaining and improving a generally favorable legal climate in which quality health care will continue to be available to the People of Maine and in which the providers of that care will find reasonably priced protection against the consequences of untoward medical results without depriving the victims of iatrogenic injury their just compensation.[100]

Among the proposals ultimately recommended by the commission for enactment were several targeting the litigation of malpractice claims. These included: (1) elimination of ad damnum clauses from malpractice complaints, (2) enactment of a ninety day notice requirement prior to filing a complaint, (3) immunity for physicians rendering voluntary services, (4) a two year statute of limitations for malpractice actions against hospitals and their employees,[101] and (5) codification of the standards for informed patient consent.[102] The commission also recommended establishing a system of voluntary binding arbitration of malpractice claims.[103] The Pomeroy Commission report was submitted to the Legislature and passed into law, becoming the original Maine Health Security Act.[104]

By 1985, lawmakers were once more concerned that rising medical malpractice premiums threatened the integrity of Maine's health care system. The legislature again responded by forming a commission to study the issue. The Professional Liability Work Group began their work in 1985. The panel looked at the issues for over a year before delivering its findings to the Legislature. The group ultimately recommended a number of new measures related to medical malpractice liability.[105] These recommendations included: (1) discovery of plaintiff's expert witnesses within 90 days of filing a claim, (2) repeal of the voluntary screening and arbitration panels, to be replaced by mandatory pre-litigation panels, (3) caps on non-economic damages, (4) limitations on attorney's contingent fees, (5) structured payment of settlements in excess of $250,000, (6) elimination of the collateral source rule, (7) reduction of the 20 year statute of limitations tail on minors claim's to six years, and (8) an occurrence-based statute of limitations for medical malpractice actions brought against health care providers, with accrual exceptions only in foreign object surgical cases.[106]

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100. *Id.* at ii. The commission recommended a variety of changes to the law, all related to one of five functional categories:

(1) Quality control over the delivery of health care services;
(2) Information and data development;
(3) Continued availability of insurance;
(4) Improvement of claims resolution; and
(5) General provisions.

Id.

101. In 1977, malpractice actions brought against physicians continued to be governed by 14 M.R.S.A. § 753.

102. THE POMEROY REPORT, *supra* note 98, at xiv.

103. *Id.* at xiii.

104. P.L. 1977, ch. 492 (codified as ME. REV. STAT. ANN. tit. 24, § 2501-2985 (West & Supp. 2000-2001)).

105. The goals of the Work Group's recommendations and the 1986 legislation they produced were to: (1) improve the efficiency of the tort system in compensating medical injuries caused by provider negligence and deterring avoidable injuries; (2) reduce medical errors and resulting injury to patients; (3) make medical malpractice insurance more available and affordable to health care providers; and (4) ensure the availability of essential health care services to residents of Maine. LIABILITY STUDY, *supra* note 64, at 29.

106. *Id.* at 31-32.

Debating the litigation reforms proposed in 1986, many legislators voiced a sense of urgency about the crisis and its effect on Maine's health care consumers.[107] Of utmost concern was the perceived negative impact on rural services, especially the availability of obstetrical care.[108] Legislators assessed the causes of the problem to be "frivolous suits,"[109] a "lottery minded public" and attorneys attempting to get "every last drop of blood available in [a] lawsuit."[110] With the problem thus defined, the Maine legislators adopted all of the litigation reforms proposed by the panel including a statute of limitations that precluded applications of the discovery rule in all but foreign object surgical malpractice actions.[111]

C. Empirical Analysis of Claim Frequency, Severity, and Adverse Patient Events

Beginning in the late 1970s, while physicians groups and lawmakers continued to focus their attention and legislative efforts on claims rates and their presumed effect on malpractice insurance premiums, some researchers began to look beyond this assumption to determine what factors were producing the record numbers of lawsuits. Between 1985 and 2000, three major independent studies on medical negligence and malpractice claims were conducted. The first of these took place in California and was published by Patricia Danzon in 1985.[112] Reviewing 1974 records from twenty-three representative hospitals and data supplied by the National Association of Insurance Commissioners, the study assessed: (1) actual incidences of medically negligent injury, (2) the number of malpractice claims filed, (3) the number of claimants compensated, and (4) the amount of compensation.[113]

Danzon's analysis of the data demonstrated that only ten percent of negligently injured patients ever filed malpractice claims, and only four percent received any compensation.[114] Danzon concluded that: (1) a patient's risk of sustaining a negligently inflicted medical injury was one in one hundred twenty-six, and (2) the frequency of claims filed significantly under-represented the number of actual occurrences.[115] Thus, according to Danzon, the overall cost of negligent medical injuries is many times greater than the cost generated by malpractice

107. Legis. Rec. 1468 (1986) (statement of Rep. MacBride). In Rep. MacBride's assessment, the problem was that "doctors are being billed huge premiums for malpractice insurance to the point that doctors in high risk specialties are giving up their professions. This is affecting health care in the State of Maine and will affect it much more if something is not done to control this problem." *Id.*

108. Legis. Rec. 1467 (1986) (statement of Rep. Jackson); Hearing on L.D. 2065 before Judiciary Committee, March 13 (testimony of Sam Barouch (Mar. 13, 1986) (Director, Provider Affairs, Blue Cross and Blue Shield of Maine) (legislative file for the Maine Health Security Act)); Hearing on L.D. 2065 (testimony of Parker F. Harris, M.D. before the Judiciary Committee (Mar. 13, 1986) (member of the Joint Professional Liability Task Force) (legislative file for The Maine Health Security Act)).

109. Legis. Rec. 1466 (1986) (statement of Rep. Allen).

110. Legis. Rec. 1465-66 (1986) (statement of Rep. Stetson).

111. P.L. 1985 ch. 804. An additional litigation reform allowing information regarding any insurance or other money received by plaintiff from "collateral sources" to be introduced into evidence was enacted in 1989. ME. REV. STAT. ANN. tit. 24, § 2906 (West 2000).

112. *See* DANZON, MEDICAL MALPRACTICE, *supra* note 1.

113. *Id.* at 18-19.

114. *Id.* at 24.

115. *Id.* at 25.

claims.[116]

Danzon's California study was followed by the 1990 Harvard Medical Practice Study.[117] Reviewing records of more than 31,000 randomly selected patients[118] hospitalized in New York State during 1984,[119] the Harvard study remains the most comprehensive analysis to date of incidences of adverse events, negligent adverse events, and legal claims filed as a result of such occurrences.[120] The Harvard researchers determined that 3.7 percent of hospitalized patients suffered some degree of injury caused by the medical care they received, and one out of one

116. *Id.*

117. *See* Brennan, *Harvard Study*, *supra* note 1, at 370; Leape, *Harvard Study*, *supra* note 1, at 1851; Weiler, *Proposal*, *supra* note 58, at 2355.

118. Brennan, *Harvard Study*, *supra* note 1, at 370. Utilizing a random sample, the Harvard researchers were able to extrapolate their data to the entire population of New York State. *Id.* at 373.

119. *Id.* at 370.

120. The medical records were reviewed at several levels. First, nurses and medical-records analysts screened each chart in the sample for indications that the patient experienced an adverse event. Brennan, *Harvard Study*, *supra* note 1, at 370. Next, records in which such an event was identified were independently reviewed by two physicians, almost always either board certified internists or surgeons trained to note evidence of adverse events and the presence or absence of related negligence. *Id.* at 370-71. Finally, a supervising physician reviewed discrepancies between the physicians' assessments. *Id.* An example of a type of adverse event found by the Harvard reviewers to have occurred in the absence of provider negligence was one in which the patient suffered an unexpected stroke as a result of properly performed angiography. *Id.* at 375. This group also would have included events in which patients with no known risk factors for heart disease suffered post-operative heart attack, and also cases where patients had an adverse reaction to a drug they had not taken previously. Leape, *Harvard Study*, *supra* note 1, at 380. These injuries were determined by the researchers to defy prediction or prevention. *Id.* In contrast, the Harvard researchers found that where a surgeon unknowingly perforated the patient's uterus, lacerated her colon, and later discharged her without further examination despite her complaints of abdominal pain, the patient's injury was related to provider negligence. *Id.* at 381.

Because the Harvard Study utilized a random sample, the results were representative of the entire patient population of New York State. Brennan, *Harvard Study*, *supra* note 1, at 373. The authors determined that of 2,671,863 discharges in the state during 1984, some 98,609 patients experienced an adverse event during their hospitalization. *Id.* Roughly 57 percent (56,042) of these patients experienced minimal disability as a result of their medical injury, recovering within a month of their discharge. *Id.* Another 13.7 percent (13,521) of patients experienced moderate disability, requiring up to six months to recover. *Id.* Finally, 2.6 percent (2,550) of patients were permanently disabled, and 13.6 percent (13,451) of patients discharged from New York hospitals in 1984 died as a result of a medical injury suffered during their hospitalization. *Id.*

The researchers next determined that of the 98,609 adverse events occurring in New York hospitals, 27,179 (including 6,895 patient deaths) were caused by negligence. *Id.* The study's authors concluded that all of these occurrences "could have led to successful litigation." *Id.* In order to determine the percentage of negligence-related injuries that resulted in a malpractice complaint, the Harvard researchers collected all claims filed by patients in New York during and after 1984 and matched these to the corresponding medical record in which the reviewers had previously identified provider negligence. *See* Weiler, *Proposal*, *supra* note 58, at 2355. The study's authors found that only one claim was filed for every 7.5 negligence-related injuries they had identified. *Id.* Further, only about half of the claims filed resulted in any award or settlement for the plaintiff. *Id.* Based on this they concluded that of the 27,179 patients who were negligently injured in New York State in 1984, only about 1,811, or one in fifteen, ever received any payment as a result of their legal claim. *Id.* Finally the Harvard Study researchers extrapolated their data to the entire population, finding that four percent of all hospitalized patients were injured as a result of medical errors. *Id.* Approximately one-quarter of these injuries were attributed to provider negligence. *Id.*

hundred patients admitted to New York hospitals suffered a negligently inflicted injury that was serious enough to result in prolongation of their hospitalization and/or disability that persisted at the time of their discharge.[121] After comparing the incidence of negligent injuries with the number of malpractice claims filed, the study's authors concluded that only 12.5 percent of negligently injured patients filed claims, and only half of those who filed received any payment.[122] The study's authors concluded that "we do not now have a problem of too many claims; if anything, there are too few."[123]

The most recent major assessment of medical injury and malpractice claim frequency was the Utah-Colorado Study.[124] In this analysis, researchers evaluated claims data and medical records in order to: "(1) . . . calculate how frequently negligent and non-negligent management of patients in Utah and Colorado in 1992 led to malpractice claims and (2) . . . understand the characteristics of victims of negligent care who do not or cannot obtain compensation for their injuries from the medical malpractice system."[125] Using an evaluation process similar to the one employed in the Harvard Study, the Utah-Colorado researchers reviewed medical records[126] from a random sample of 15,000 patients discharged from hospitals in those states during 1992.[127] This sample was then linked to medical malpractice claims data obtained directly from insurers in Utah and Colorado.[128] The researchers analyzed the records to identify negligent and non-negligent adverse events.[129]

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121. Brennan, *Harvard Study*, *supra* note 1, at 341.

122. *See* W. John Thomas, *The Medical Malpractice "Crisis": A Critical Examination of a Public Debate*, 65 TEMP. L. REV. 459, 485 (1992) [hereinafter Thomas, *Crisis*] (citing A. Russell Localio et al., *The Relationship Between Malpractice Claims and Adverse Events Due to Negligence*, 325 NEW ENG. J. MED. 295, 248 (July 25, 1991)).

123. *Id.* (quoting HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK (Report of the Harvard Medical Practice Study to the State of New York) 11-4 (1990)).

124. *See* Studdert, *Utah-Colorado Study*, *supra* note 1, at 250-60; Thomas, *Utah-Colorado Study*, *supra* note 1, at 261-71. The Danzon California study differed from both the Harvard and Utah-Colorado studies in at least one significant respect. Danzon's conclusions were arrived at after examining data from two separate pools: medical records and aggregate insurance claims data. Daniel M. Studdert and Troyen A. Brennan, *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 IND. L. REV. 1643, 1648 (2000) [hereinafter *Dead Reckoning*]. Specific medical injuries identified from patient records were not, however, matched to specific claims. *Id.* Both the Harvard and the Utah-Colorado studies did make that connection, allowing the researchers to additionally identify meritless negligence claims. *Id.* at 1649-50, 1657-62.

125. Studdert, *Utah-Colorado Study*, *supra* note 1, at 250.

126. The medical records evaluated included pre-hospitalization records. The California and Harvard studies were limited to medical data collected from in-patient hospital records. *See* DANZON, MEDICAL MALPRACTICE, *supra* note 1, at 18-19; Brennan, *Harvard Study*, *supra* note 1, at 370.

127. *See* Studdert, Utah-Colorado Study, *supra* note 1, at 251. Studdert and Brennan conducted the Utah-Colorado research in part to "validate" the Harvard study, which they believed contained methodological peculiarities that cast doubt upon its currency in the age of managed care, and on the reliability with which data from New York could be applied to other geographical areas and populations. *Dead Reckoning*, *supra* note 124, at 1652-55.

128. *See* Studdert, *Utah-Colorado Study*, *supra* note 1, at 252.

129. *See id.* at 251-52. Negligent adverse events were defined as "actual injuries proximately resulting from a treating physician's failure to meet the standard expected in his practice community." *Id.* at 252.

From the 50,000 records reviewed, the Utah-Colorado team identified 587 adverse medical events.[130] Of these, 161 were found to have resulted from provider negligence.[131] When these figures were extrapolated to the entire population of each state, the researchers estimated that 1,828 negligent adverse events related to hospitalized patients occurred in Utah during 1992, and 3,179 occurred in Colorado.[132]

Next, comparing the noted adverse events to malpractice claims, the Utah-Colorado researchers matched eighteen records to claims.[133] Four of these claimants were determined to have sustained a negligent medical injury.[134] Thus, negligence was present in only twenty-two percent of claims filed. The data also showed, however, that ninety-seven percent of patients who suffered a negligent adverse medical event either prior to, or during hospitalization, did not file a claim.[135]

The results and conclusions of the 1992 Utah-Colorado Study generally agreed with those arrived at in both the Harvard Study (analyzing 1980 data) and Danzon's California Study (1974 data), supporting the assertion that victims of medical negligence are, on average, grossly under-compensated for their injuries. The Utah-Colorado Study, however, also identified a high incidence of "false-positives," i.e., meritless claims filed against physicians.[136] Nonetheless, the authors found the frequency of malpractice claims filed "lag[s] well behind the incidence of negligent injury."[137]

IV. MAINE'S CURRENT STATUTE OF LIMITATIONS FOR MEDICAL MALPRACTICE

A. Structure and Policy Considerations

Statutes of limitation, which by definition act to limit legal rights, have historically served states' interests by inhibiting the litigation of stale claims.[138] According to the underlying rationale, as time passes the quality and availability of evidence and witness' testimony diminishes. As a result, defendants are more likely to be prejudiced in their attempts to present a case.[139] It is also asserted that

130. *Id.* at 253.

131. *Id.* One of eleven negligent adverse events identified in the study resulted in the patient's death. *See* Orentlicher, *supra* note 1, at 247.

132. Studdert, *Utah-Colorado Study*, *supra* note 1, at 253.

133. *Id.*

134. *Id.*

135. *Id.* at 250, 253. The data also demonstrated that the elderly and the poor, i.e., those most in need of compensation, were the least likely groups to file a malpractice claim after they sustained a negligent medical injury. *Id.* at 250.

136. *Id.* at 258.

137. *Id.*

138. *See Developments*, *supra* note 11, at 1177.

139. Chase Securities Corp. v. Donaldson, 325 U.S. 304, 314 (1944). According to the Court:

> Statutes of limitations find their justification in necessity and convenience rather than in logic. They represent expedients, rather than principles. They are practical and pragmatic devices to spare the courts from litigation of stale claims, and the citizen from being put to his defense after memories have faded, witnesses have died or disappeared, and evidence has been lost. They are by definition arbitrary, and their

defendants have a legitimate right to security after the passage of a certain amount of time.[140] Legislatures also enact statutes of limitation for other purposes, such as governmental policies favoring or disfavoring "certain types of claims or certain classes of plaintiffs or defendants."[141]

Every state possesses a general statute of limitations fixing the time that actions related to various property, contract and tort interests may be brought, as well as most criminal actions.[142] Many states have also enacted individualized statutes of limitation for certain types of cases. Such statutes are designed to deal with unique circumstances and many times do not conform to traditional limitations rules.[143] A common feature of such special statutes is a relatively short period in which a claim may be asserted. Less frequently, statutes bar a future interest "even though not yet ripened into a possessory right."[144]

All states apply statutes of limitation to medical malpractice actions.[145] States' limitations provisions differ from each other primarily in the degree of protection provided to opposing parties from two elements of the statutes: the length of time after a cause of action accrues in which a claim may be filed, and the definition of accrual for purposes of commencing the running of the limitations period.[146] Although the length of state statutes of limitation are uniformly set by legislatures, the definition of accrual may be established by statute or, alternatively, left open for judicial determination within the context of a particular case or class of cases.[147] Regardless of whether it is statutorily or judicially defined, accrual of medical malpractice actions generally occurs at one of two points: (1) occurrence of the negligent act (or omission) giving rise to the injury, or (2) the time at which a

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operation does not discriminate between the just and the unjust claim, or the voidable and unavoidable delay. They have come into the law not through the judicial process but through legislation. They represent a public policy about the privilege to litigate.

Id. (citations omitted).

140. *Developments, supra* note 11, at 1184. The author notes that "[t]he primary consideration underlying such legislation is undoubtedly one of fairness to the defendant. There comes a time when he ought to be secure in his reasonable expectations that the slate has been wiped clean of ancient obligations." *Id.* In litigation between private parties, the benefit to the public argued to come from avoiding "the disrupting effect that unsettled claims have on commercial intercourse." *Id.* at 1185. Efficient functioning of the court system is yet another time related policy cited to support statutes of limitation. *Id.* at 1185.

141. *Id.* at 1185-86.

142. *Id.* at 1180. In most states, murder, manslaughter, forgery, and arson are excluded from application of the statute of limitations. *Id.*

143. *Id.* at 1179.

144. *Id.* at 1180.

145. *See* Peter Zablotsky, *From a Whimper to a Bang: The Trend Toward Finding Occurrence Based Statutes of Limitations Governing Negligent Misdiagnosis of Diseases With Long Latency Periods Unconstitutional,* 103 DICK. L. REV. 455, 461-62 (1999); David W. Feeder II, Comment, *When Your Doctor Says, "You Have Nothing to Worry About," Don't Be So Sure: The Effect of* Fabio v. Bellomo *on Medical Malpractice Actions in Minnesota,* 78 MINN. L. REV. 943, 950-51 (1994).

146. Bovbjerg, *Legislation, supra* note 59, at 524; *see also* Feeder, *supra* note 150, at 950-51.

147. Michael John Byrne, *Survey of Developments in North Carolina and the Fourth Circuit, 1994: I; CIVIL PROCEDURE: Let Truth Be Their Devise:* Hargett v. Holland *and the Professional Malpractice Statute of Repose,* 73 N.C. L. REV. 2209, 2217 (1995).

plaintiff discovers or reasonably should discover the injury.[148] The second type of accrual is commonly referred to as the discovery rule.[149]

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148. Zablotsky, *supra* note 145, at 461-63. Accrual may be further differentiated. Zablotsky identifies four categories of accrual present in State medical malpractice statutes of limitation:

> [1] [O]ccurrence based [accrual] with no discovery exceptions whatever . . . . *See* ALASKA STAT. § 09.10.070(b) (Michie 1999); CONN. GEN. STAT. ANN. § 52-584 (West 1991); MINN. STAT. ANN. § 541.07(1) (West 1998); NEB. REV. STAT. § 25-222 (1995); N.J. STAT. ANN. § 2A:14-2 (West 1987); 42 PA. CONS. STAT. ANN. § 5524(2) (West Supp. 1998); S.D. CODIFIED LAWS § 15-2-14.1 (Michie 1998).
>
> [2] [O]ccurrence based with limited discovery exceptions for malpractice actions involving either minors, fraudulent concealment, continuous treatment, or foreign objects. . . . The discovery period . . . is capped at a stated number of years . . . . *See* ALA. CODE § 6-5-482(b) (1993) (infancy); ARIZ. REV. STAT. ANN. § 12-542 (1992) (foreign object); ARK. CODE ANN. § 16-114-203(b)-(d) (Michie 1997) (foreign object, infancy, and incompetency); CAL. CIV. PROC. CODE § 340.5 (West 1982) (fraud, intentional concealment, foreign object, and infancy); ILL. COMP. STAT. 5/13-212 (West 1998) (fraudulent concealment, infancy); IND. CODE ANN. § 34-18-7-1(b) (West 1998) (infancy); MO. ANN. STAT. § 516.105 (West Supp. 1999) (infancy, foreign object); N.D. CENT. CODE 28-01-18(4) (1991) (fraudulent concealment); TEX. REV. STAT. ANN. art. 4950i (West 1998) (infancy); VT. STAT. ANN. tit. 12, § 521 (Cumulative Supp. 1998) (fraudulent concealment, foreign object); VA. CODE ANN. § 8.01-243(c) (Michie 1992) (fraudulent concealment, foreign object); WASH. REV. CODE ANN. § 4.16.350(3) (West Supp. 1997) (fraudulent concealment, foreign object); WIS. STAT. ANN. § 893.55(2)-(3) (West 1997) (fraudulent concealment, foreign object); WYO. STAT. ANN. § 1-3-107(a)(ii)-(iii) (Michie 1977) (infancy, legal disability). . . .
>
> [3] [O]ccurrence based with discovery exceptions for minors, fraudulent concealment, continuous treatment or foreign objects, but the period applicable to the exceptions is not capped. . . . *See* DEL. CODE ANN. tit. 18, § 6856 (1989) (infancy); IDAHO CODE § 5-219(4) (1998) (fraudulent concealment, foreign object); IOWA CODE § 614.1(9) (West 1997) (foreign object); ME. REV. STAT. ANN. tit. 24, § 2902 (West 1990) (foreign object); MASS. GEN. LAWS ANN. ch. 260, § 4 (West 1992) (foreign object); MISS. CODE ANN. § 15-1-36(1)(a)-(b) 23.12 (West Supp. 1999) (foreign object, fraudulent concealment); *id.* § 15-1-49(2) (West 1995) (latent disease); N.Y. C.P.L.R. 214-a (McKinney Cumulative Supp. 1999) (continuous treatment, foreign object); W. VA. CODE § 55-7B-4(b)-(c) (1998) (infancy, fraudulent concealment). . . .
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> [4] [D]iscovery based for all medical malpractice causes of action, but the discovery period is capped. . . . *See* GA. CODE ANN. § 9-3-71(b) (Harrison 1998); HAW. REV. STAT. 657-7.3 (Michie 1993) (fraudulent concealment, infancy); KAN. STAT. ANN. 60-513(7)(b) (1994); KY. REV. STAT. ANN. § 413.140(2) (Banks-Baldwin 1998); LA. REV. STAT. ANN. § 9:5628(A) (West Supp. 1999); MD. CODE ANN. CTS. & JUD. PROC. § 5-109(b) (Michie 1998) (infancy); MICH. COMP. LAWS ANN. § 600.5838(a) (West 1998) (fraudulent concealment, infancy, reproductive organs); MONT. CODE ANN. § 27-2-205(2) (1997) (infancy); NEV. REV. STAT. ANN. § 41 A.097(2)-(3) (Michie 1986) (fraudulent concealment, infancy, brain damage, birth defect, sterility in minor); N.H. REV. STAT. ANN. § 508:4 (1998); OKLA. STAT. ANN. tit. 76, § 18 (West 1995) (infancy, incompetency); OR. REV. STAT. § 12.110(4) (1997); R.I. GEN. LAWS 9-1-14.1(1) (1997) (infancy, incompetency); S.C. CODE ANN. § 15-3-345(B),(D) (West Supp. 1998) (foreign object, infancy); TENN. CODE ANN. § 29-26-116(3) (1980) (fraudulent concealment); UTAH CODE ANN. § 78-14-4(1) (fraudulent concealment, foreign object). . . .
>
> Only the District of Columbia [has] adopted a pure discovery based statute. *See* D.C. CODE ANN. § 12.301(8) (1995).

Id. at 461-63 n.21-24. In addition to foreign object surgical cases, Maine's statute of limitations for health care providers and health care practitioners is tolled for incompetency through reference to a separate statutory provision. ME. REV. STAT. ANN. tit. 24, § 2902 (West 1999) (referencing ME. REV. STAT. ANN. tit. 14, § 853 (West 1999)).

149. Byrne, *supra* note 147, at 2218.

Of the two forms of accrual, occurrence-based accrual provides the most rigid, finite rule. Under occurrence-based accrual, the running of the statute of limitations for medical malpractice is triggered by allegedly negligent events that may or may not reasonably have been apparent to either the plaintiff or the defendant.[150] Discovery based accrual is technically an exception to statutes of limitation whereby the running of the statute is tolled, or delayed, until such a time as a plaintiff knows or reasonably should know his or her cause of action exists.[151] The rule is most commonly employed in situations where a plaintiff's injury was inherently undiscoverable and is of such a nature that the injury and its cause are capable of proof by objective facts.[152]

In medical malpractice cases, application of the discovery rule is commonly argued for as a policy that fairly balances the harm incurred by blameless plaintiffs against the importance of repose and security for defendants. The necessary reliance of patient-plaintiffs on the defendant-health care providers is also a factor cited by those favoring applications of the rule.[153] Under the discovery rule, accrual of a cause of action for medical malpractice normally cannot occur absent a plaintiff's awareness that he or she has been injured. Thus, pure discovery-based accrual could potentially leave open indefinitely the possibility of future litigation when a medical injury remains undetected over an extended period of time. With one exception, all states utilizing the discovery rule have dealt with this issue by placing an outer time limit on the viability of such claims.[154]

B. The Evolution of Maine's Statute of Limitations for Medical Malpractice

Prior to the enactment of the present three-year occurrence-based limitations provision, both the Maine Legislature and the state's courts utilized a variety of approaches in structuring and applying statutes of limitation to medical malpractice actions in Maine. As the rule evolved, changes in policy as well as the relative weights afforded plaintiffs' rights to redress and defendants' rights to repose have produced fluctuations in both the length of the statutory period and the definition of accrual. Although the length of the limitations period has always been fixed by the legislature, until recently the definition of accrual was left open for judicial determination.[155]

The issue of accrual in medical malpractice actions was first directly addressed by the Maine Supreme Judicial Court, sitting as the Law Court, in the 1962 case of *Tantish v. Szendy*.[156] In that case, the defendant surgeon asserted the two-year statute of limitations as a defense against the plaintiff's allegation that he had negligently failed to remove surgical tubing from her body at the conclusion of her operation.[157] The error was not discovered until some twenty-two months after surgery, and a claim was not filed for an additional year plus 364 days.[158]

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150. Feeder, *supra* note 145, at 951 & n.43.

151. Feeder, *supra* note 145, at 952-53 & n.45 (citing United States v. Kubrick, 444 U.S. 111 (1979)).

152. *See id.*

153. Myrick v. James, 444 A.2d at 995.

154. Zablotsky, *supra* note 145, at 463.

155. *See supra* note 12.

156. 158 Me. 228, 182 A.2d 660 (1962).

157. *Id.* at 229, 182 A.2d at 660.

158. *Id.*

According to the *Tantish* court, the pivotal question in determining whether the statute of limitations had run on the plaintiff's cause of action was "[w]hen did the action accrue?"[159] If accrual occurred at the moment of the alleged act, i.e., the operation, then the statute was a bar.[160] But if her action did not accrue until she discovered the error and related injury, her claim was timely commenced.[161] Noting that statutes of limitation "in their operation cut off both meritorious and unmeritorious claims,"[162] the court found the decision to rest "upon the choice to be made between competing policies."[163] The court went on to explain that:

> On the one hand there is what appears to be justice for the patient in commencing the accrual of the right of action when the negligence of the defendant is discovered, or reasonably should have been discovered and not before. How, says the patient, may I . . . bring an action until the wrong . . . is known to me?
>
> On the other hand, the [defendant] may with justice urge that the statute of limitations is a statute of repose designed by the Legislature to cut off claims which grow increasingly stale with greater age.[164]

After weighing these considerations, the court found the defendant's right to repose to be paramount.[165] It ruled accordingly that the plaintiff's cause of action had accrued at the time of her operation.[166] Of importance to the court in its analysis was that "[i]n retrospect the time of the particular wrongful act [could be] readily fixed."[167] The court also noted the current "weight of authority" endorsed occurrence-based accrual.[168]

The discovery rule was first applied in Maine to toll the statute of limitations in a medical malpractice action in the 1982 case of *Myrick v. James*.[169] In *Myrick*, the Law Court considered a complaint involving a foreign object negligently left in the plaintiff's body during surgery.[170] The mistake went undiscovered for almost seven years.[171] Noting the plaintiff's reliance on her doctor, the inherently undiscoverable nature of her injury, as well as the presence of objective and well-preserved evidence (a surgical sponge removed from her abdomen during a subse-

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159. *Id.* at 230, 182 A.2d at 661.
160. *See id.*
161. *See id.*
162. *Id.*
163. *Id.* at 231, 182 A.2d at 661.
164. *Id.* at 230, 182 A.2d at 661.
165. *Id.* at 230-31, 182 A.2d at 661.
166. *Id.* at 237, 182 A.2d at 664.
167. *Id.* at 231, 182 A.2d at 660. The court did not fully explain why the ability to fix the time of the act with absolute certainty should be determinative. It did, however, go on to distinguish the instant case from one in which a continuous course of treatment would be at issue: "In such a case it would be difficult and perhaps impossible to determine the precise moment in which a particular negligent act or acts occurred." *Id.* at 231, 182 A.2d at 661. The court also found noteworthy the fact that the plaintiff had discovered her injury approximately six weeks less than two years after the operation; had she acted with expediency, she could have brought her claim "with no question of the applicability of the statute." *Id.* According to the court, however, "[t]he relative lack of hardship to the plaintiff arising from the discovery before and not after the two-year period [was] given no weight . . . in determining the applicable rule." *Id.*
168. *Id.*
169. 444 A.2d 987, 991 (Me. 1982).
170. *Id.* at 996.
171. *Id.*

quent operation), the court determined that strict adherence to occurrence-based accrual would work a "manifest injustice."[172] Based on these considerations, the court concluded that the proper balance of litigant's rights was best achieved by holding that in such circumstances a cause of action accrues "when the plaintiff discovers, or, in the exercise of reasonable care and diligence, should discover the presence of the foreign object in her body."[173]

Following *Myrick*, the Law Court extended application of the discovery rule in foreign object surgical cases to claims involving negligent misdiagnosis or treatment of latent illnesses that were similarly undiscoverable.[174] First, in *Bolton v. Caine*,[175] the court considered allegations that the defendant physicians had been negligent in failing to inform Bolton, deceased at the time of trial, of an abnormality on her chest x-ray indicative of lung cancer, and of the need to obtain further testing.[176] Bolton independently learned she had cancer approximately ten months later.[177] She discovered the defendants' negligence approximately thirteen months after the initial x-ray had been taken.[178] Her estate filed suit roughly three years after the alleged act of negligence occurred, but within two years (the statutory limitations period in force at the time) of Bolton's discovery of that act.[179]

Hearing Bolton's appeal of the trial court's dismissal of her suit as time barred, the Law Court drew comparisons to the discovery of the foreign object at issue in *Myrick*:

> In both [cases] the plaintiffs [were] blamelessly ignorant of their latent medical conditions, and their resulting failure to seek medical help . . . . [Bolton] had reason to rely on the defendants to correctly diagnose and inform her of a lesion appearing on x-ray, and the alleged results of that failure are as catastrophic as they were for Mrs. Myrick.[180]

Commenting on the defendants' attempt to differentiate their case from *Myrick* based on nature and quality of the evidence,[181] the court gave no opinion as to

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172. *Id.* at 995.

173. *Id.* at 996. Prior to reaching this holding, the Law Court noted that, although the Legislature had previously considered, but not adopted, the discovery rule for medical malpractice actions, the legislative record was silent on the issue. The court interpreted this silence as an indication of the Legislature's intention to leave the definition of accrual in individual medical malpractice actions to the judiciary. *Id.* at 993 (citing Anderson v. Neal, 428 A.2d 1189, 1191 (Me. 1981)).

174. Box v. Walker, 453 A.2d 1181, 1182 (Me. 1983). Following *Myrick*, in 1983, the Law Court rejected an appeal of a dismissal based on the statute of limitations in a case involving a failed tubal ligation, where pregnancy occurred after the statutory period had run. The court's decision, however, did not address the merits of the discovery rule. The court instead based its ruling on its authority to apply the discovery rule in a prospective fashion only. *Id.* at 1182-83. In a concurring opinion, two of the Justices did express concern about applications of the discovery rule beyond foreign object surgical cases, citing the need for "uniformity and certainty in the application of the legal doctrine." *Id.* at 1183-84.

175. 541 A.2d 924 (Me. 1988).

176. *Id.* at 924-25.

177. *Id.*

178. *Id.* at 925.

179. *Id.*

180. *Id.* at 926.

181. According to the court, the defendants argued that "negligent diagnosis cases are different, result in injury less clearly defined, involve more questions of professional judgment and discretion than foreign object cases, and, unlike foreign object cases, always require expert medical testimony." *Id.* at 925.

whether the x-ray showing a lesion was comparable to the foreign object removed from Myrick.[182] It responded only that it would not "make the application of the discovery rule solely dependent on the type of evidence that may be produced at trial."[183]

Next, in *Black v. Ward*,[184] plaintiff Black alleged physician negligence related to a malignant skin lesion her doctor had examined.[185] The Law Court heard an appeal of the trial court's grant of summary judgment to the defendant based on expiration of the statute of limitations.[186] Having filed notice of claim some four years after the alleged negligence occurred, but less than two years[187] after she discovered the error, Black asserted that the trial court erred in refusing to apply the discovery rule to her action.[188] In opposition, the defendant argued "the discovery rule should not be applied to [the] case because of the absence of tangible physical evidence, such as an x-ray, present in *Bolton*."[189] But the court, noting that it had rejected any such evidence-based test in *Bolton*, found the determination of whether the discovery rule could fairly be applied to the facts at hand to instead rest on the "reliance on the physician by the patient."[190] Based on this, the court "concluded that" the resulting blameless ignorance on the part of the patient as to the cause of her condition compelled the application of the discovery rule to the negligent diagnosis or failure to communicate a diagnosis case."[191]

Even as the Law Court issued these 1988 rulings expanding applications of discovery-based accrual to inherently undiscoverable medical injury actions, it was aware that policy would be short-lived.[192] As noted in Part III, in 1986, responding to the perceived medical malpractice insurance crisis, the 112th Legislature passed a number of provisions that altered the rules governing litigation of malpractice claims. Included among these measures was 24 M.R.S.A. section 2902, the Statute of Limitations for Health Care Providers and Health Care Practioners.[193] The statute governs actions filed after August 1, 1988.[194]

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182. *Id.*

183. *Id.* at 926.

184. 549 A.2d 371 (Me. 1988).

185. *Id.* at 371.

186. *Id.*

187. Like *Bolton v. Caine*, the parties in *Black v. Ward* were governed by the two-year statute of limitations provided in 14 M.R.S.A. section 753. *See* ME. REV. STAT. ANN. tit. 14, § 753 (West 1980).

188. Black v. Ward, 549 A.2d at 371-72.

189. *Id.* at 372. In *Black*, the negligence claimed was the physician's physical examination and misdiagnosis of a malignant skin lesion as benign. *Id.* Because no biopsy was obtained at the time of the alleged error, the court found that no "tangible physical evidence" of negligence was available for trial. *Id.* at 371-72.

190. *Id.* at 372.

191. *Id.*

192. As the Law Court noted in both *Bolton* and *Black*, by the time those cases were decided the Legislature already had passed 24 M.R.S.A. section 2902. Black v. Ward, 549 A.2d at 372; Bolton v. Caine, 541 A.2d 924, 926 n.3 (Me. 1988). The new statute of limitations, however, was made applicable only to actions filed after August 1, 1988, exempting both cases. Black v. Ward, 549 A.2d at 372; Bolton v. Caine, 541 A.2d at 925 n.2.

193. P.L. 1985, ch. 804, § 13 (codified as ME. REV. STAT. ANN. tit. 24, § 2902 (West Supp. 1987)). For the text of the provision, see *supra* note 8.

194. ME. REV. STAT. ANN. tit. 24, § 2902 (West 1999).

Presently, under section 2902, the time period in which a medical malpractice claim may be brought is increased (from the previous two years) to three years after accrual of a plaintiff's cause of action.[195] In all but foreign object surgical cases, however, judicial determinations of what constitutes accrual are now foreclosed.[196] Unlike its predecessor statutes of limitation, section 2902 expressly states that a cause of action for medical malpractice "accrues on the date of the act or omission giving rise to the injury," regardless of when that injury becomes apparent.[197]

V. CONSTITUTIONAL CHALLENGES TO ME. REV. STAT. ANN. TITLE 24, SECTION 2902

Following its enactment in 1988, Maine's current occurrence-based statute of limitations for medical malpractice, as applied to cases involving latent medical error, has faced two interesting constitutional challenges. The first was *Choroszy v. Tso*.[198] In 1988, plaintiff Choroszy consulted Dr. Tso for evaluation of his hearing loss.[199] At the doctor's instruction, Choroszy underwent a CAT scan.[200] The radiologist's report of the scan found no obvious abnormalities, but acknowledged that more refined testing (magnetic resonance imaging) was appropriate in order to identify cancerous lesions that might not be apparent on the CAT scan.[201] For reasons undisclosed, the radiologist's recommendation was never communicated to Choroszy.[202] Unaware that he might have cancer, Choroszy did not seek further treatment until his symptoms worsened in 1992.[203] By that time, the malignant growth had spread to involve the surrounding tissues, producing significant injury.[204] Alleging Tso was negligent in failing to notify him of the need for further testing, Choroszy filed the required notice of claim approximately five years after his treatment with Tso was discontinued.[205] Tso successfully moved for dismissal, asserting that the claim was barred by the expiration of the three-year statute of limitations.[206]

On appeal, Choroszy argued the unconstitutionality of the statute of limitations under the Open Courts provision of the Maine Constitution[207] and the Equal Protection Clauses of the Maine and United States Constitutions.[208] According to

195. *Id.*
196. *Id.*
197. *Id.*
198. 647 A.2d 803 (Me. 1994).
199. *See id.* at 805.
200. *Id.*
201. *Id.*
202. *Id.*
203. *Id.*
204. *Id.*
205. *Id.*
206. *Id.*
207. *See* ME. CONST. art. I, § 19. The provision reads: "Every person, for an injury done him in his person, reputation, property or immunities, shall have remedy by due course of law; and right and justice shall be administered freely and without sale, completely and without denial, promptly and without delay." *Id.*
208. *Compare* U.S. CONST. amend. XIV, § 1 with ME. CONST. art. I, § 6A. The equal protection guarantees provided for in the Maine Constitution are equivalent to those of the United States Constitution. *See* School Admin. Dist. No. 1 v. Commissioner of Educ., 659 A.2d 854, 857 (Me. 1995).

Choroszy, application of the occurrence-based accrual provision of section 2902 was unreasonable because he did not and could not have known about the negligent error related to his diagnosis until more than four years after the occurrence.[209] Because of this, Choroszy asserted, application of the statute to his claim extinguished his cause of action before he could have discovered its existence, thus denying him his constitutionally guaranteed access to the courts.[210]

Choroszy based his Equal Protection challenge on the arbitrary classifications of medical malpractice plaintiffs created by the statute. According to Choroszy, the statute's accrual provisions irrationally distinguished between foreign object surgical plaintiffs (to whom the discovery rule was available) and those who suffer medical misdiagnosis of a latent illness.[211]

Considering the Open Courts challenge, the Law Court, applying deferential scrutiny, determined the question presented to be: "[W]hether by requiring a medical malpractice victim to discover his injury within three years of the act or omission 'giving rise to' the injury, the Legislature has imposed 'time limits so unreasonable as to deny meaningful access to the judicial process.'"[212] Without directly addressing the conflict created by the undiscoverable nature of the injury, the court held that the time limit imposed upon Choroszy was not unreasonable.[213] It supported this conclusion by noting that in *Tantish v. Szendey*,[214] the court itself had endorsed strict occurrence-based accrual in similar circumstances.[215] Further, the court offered that "[t]he law remains with regard to most other torts that a cause of action accrues at the time of the judicially recognizable injury, despite the plaintiff's reasonable failure to discover the harm."[216] Finally, the court offered that the legislature had contemplated hardships such as Choroszy's when it enacted section 2902, and their analysis on the issue was above examination: "the 'power of the legislature to shorten the period of expiration . . . has been too often recognized by courts of the highest respectability to be questioned now.'"[217]

The court also upheld the statute on Equal Protection grounds.[218] Determining that neither a fundamental interest nor a suspect class was involved, the court again applied rational-basis scrutiny in holding that the disparate treatment of two like-situated groups of plaintiffs, latent injury and foreign object surgical injury

209. Choroszy v. Tso, 647 A.2d at 806.

210. *Id.*

211. *Id.*

212. *Id.; see also* Maine Med. Ctr. v. Cote, 577 A.2d 1173 (Me. 1990). In *Cote*, the Law Court heard similar challenges to the statute of limitations, but in that case the alleged infringement on the plaintiff's rights was related not to the type of claim, but instead to his minority. *Id.* at 1175. Section 2902 of title 24 provides that "[actions] for professional negligence by a minor shall be commenced within 6 years after the cause of action accrues or within 3 years after the minor reaches the age of majority, whichever first occurs." ME. REV. STAT. ANN. tit. 24, § 2902 (West 1990). Cote argued that for children who sustain a negligent medical injury while still under the age of twelve, the limitations period would invariably run before they could reach adulthood and bring an action in their own name. Maine Med. Ctr. v. Cote, 577 A.2d at 1176. In rejecting Cote's Open Courts challenge, the court's rationale in upholding the statute was essentially the same one expressed in *Choroszy*, finding that the time period provided by the statute was "reasonable." *Id.* at 1176. For a more detailed discussion of Open Courts analysis, *see infra*, note 233.

213. Choroszy v. Tso, 647 A.2d at 807.

214. 237 A.2d 660 (Me. 1962).

215. Choroszy v. Tso, 697 A.2d at 807.

216. *Id.* (citation omitted).

217. *Id.* (quoting Maine Med. Ctr. v. Cote, 577 A. 2d 1173, 1176 (Me. 1990)).

218. *Id.* at 807-08.

victims, was rationally related to the legitimate state interest of controlling malpractice insurance and related health care costs.[219] According to the court, the constitutional question was tied to the legislature's intentions when the statute was enacted: "The state's objective[s]—to control the cost of medical malpractice insurance and of health care in general—[are] legitimate one[s], and a statute of limitations is a rational way to achieve that objective."[220]

A perfunctory Due Process challenge to section 2902 was heard in the 1996 case of *Dasha v. Maine Medical Center*.[221] In that case, Mr. Dasha suffered a severe brain injury secondary to radiation treatments he received after his doctors mistakenly diagnosed him as having an aggressive brain tumor.[222] The medical errors leading to Dasha's injury were discovered approximately two years and nine months after the misdiagnosis.[223] A notice of claim for medical negligence was filed on Dasha's behalf approximately fourteen months later, more than a year after the statute of limitations had run.[224]

After Dasha's pleas for equitable tolling of the statute of limitations based on his mental incapacity were rejected by the Law Court, he argued in federal district court that the denial of that relief violated the Due Process Clause of the United States Constitution.[225] The court rejected the argument, noting that at the time of

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219. *Id.* at 808. Equal Protection guarantees prevent the state from arbitrarily creating a legislative classification of people who are deprived of rights available to others. *See* Vacco v. Quill, 521 U.S. 793, 799 (1997). Under Equal Protection analysis, if a plaintiff demonstrates that the statute involves a suspect classification or a fundamental interest, courts apply strict scrutiny, upholding the statute only if it is narrowly tailored to effectuate a compelling state interest. Loving v. Virginia, 388 U.S. 1, 11 (1967). Where courts find quasi-suspect classifications, heightened scrutiny may be applied and the statute's constitutionality depends on whether the classification bears a substantial relationship to an important state interest. Lalli v. Lalli, 439 U.S. 259, 265 (1978). Where courts find no suspect or quasi-suspect class or fundamental right at issue, the statute receives only rational-relationship scrutiny. Vacco v. Quill, 521 U.S. at 799. Under this differential test, the statute is constitutional as long as the court finds the legislature's creation of the classification was intended to serve a legitimate state interest. *Id.*

220. Choroszy v. Tso, 647 A.2d at 808. The *Cote* court also heard an Equal Protection argument, holding similarly to the *Choroszy* court:

> The State in its fullest exercise of sovereignty has the inherent power to pass regulations designed to promote the public health, safety and welfare, and that the regulatory means must bear a rational relationship to the evil sought to be corrected. The *stated purpose* of the tort reform bill [of which section 2902 was a provision] was to expedite the resolution of medical liability claims in order to decrease the high costs of medical professional liability insurance.
>
> . . . .
>
> . . . [I]f the measure is *reasonably appropriate* to accomplish the intended purpose we must give it effect.

Maine Med. Ctr. v. Cote, 577 A.2d at 1176-77 (citations omitted) (emphasis added).

221. 918 F. Supp. 25 (D. Me. 1996); *see* U.S. CONST. amend. V; U.S. CONST. amend. XIV, § 1. The Due Process Clause guarantees that no person shall be deprived of "life, liberty or property without due process of law." U.S. CONST. amend. XIV, § 1.

222. Dasha v. Maine Med. Ctr., 918 F. Supp. at 26.

223. *Id.*

224. *Id.* at 26-27.

225. *Id.* at 27; *see also* Dasha v. Maine Med. Ctr., 665 A.2d 993 (Me. 1995) (ruling on a question of state law certified by the federal district court). Dasha also challenged the Law Court's denial of equitable relief under the Open Courts Clause of the Maine Constitution. The federal district court dismissed the challenge, commenting only that "even '[i]f section 2902 may have the effect of foreclosing access to the courts in some case, it certainly did not have that effect in this case.'" Dasha v. Maine Med. Ctr., 918 F. Supp. at 27 n.2 (citation omitted) (quoting Order Certifying Question of State Law to the Law Court (Docket No. 12) at 5).

discovery, Dasha was still within the statutory period allowed under section 2902.[226] The court then went on to address the Due Process issue raised by strict occurrence-based accrual: "To the extent that the statute generates a harsh result in this case . . . it is for lack of a discovery rule rather than for lack of an exception [even] when a plaintiff's injury impedes mental capacity."[227] According to the court, in considering such a Due Process challenge the appropriate level of constitutional scrutiny for statutes of limitation is rational-basis.[228] Further, rationality of the statute is presumed, i.e., the party challenging must show that it does not bear a rational relationship to a legitimate state interest.[229] Finally, the court found that where there is a rational relationship, statutes of limitation are constitutional "if a reasonable time is given for the commencement of an action before the bar takes effect."[230] Examining section 2902, the court stated that "in expressly limiting the application of the discovery rule, the Maine legislature undoubtedly considered the enormous individual human costs of cases just such as this, but decided nonetheless that those costs are outweighed by the pressing need to control health costs for all."[231]

VI. DISCUSSION

As the *Dasha* and *Choroszy* decisions demonstrate, under the deferential standard of review employed by courts in Maine evaluating constitutional challenges

226. Dasha v. Maine Med. Ctr., 918 F. Supp. at 28.

227. *Id.*

228. *Id.* at 27. Although the *Dasha* court did not make the distinction, courts often differentiate between substantive and procedural due process challenges. Zablotsky, *supra* note 150, at 478-79. Court considerations of substantive Due Process challenges to statutes of limitation are often similar to the Equal Protection analysis. *Id.* at 479. Substantive Due Process recognizes that where a fundamental individual right is at issue the validity of any law restricting that right is dependent upon whether it is narrowly tailored to effectuate a compelling state interest. Zablocki v. Redhail, 434 U.S. 374, 388 (1978). Where no fundamental right is at issue, however, the statute must only be rationally related to a legitimate state interest. *Id.*

Procedural Due Process analysis (as well as Open Courts Clause scrutiny) considers whether the operation of a particular statute of limitations is so restrictive that, by denying a plaintiff any meaningful opportunity to pursue his or her claim through the legal system, enforcement of the statute constitutes a taking of the plaintiff's property interest in their cause of action without due process of law. *See* Zablotsky, *supra* note 150, at 478-79. Procedural Due Process challenges have primarily involved occurrence-based statutes of limitation applied to claims where the injury was not apparent until after the statute had run. In the absence of a discovery rule, plaintiffs argue, they are locked out of the courthouse before their cause of action exists. *Id.* at 480-81 (discussing Estate of Makos v. Wisconsin Masons Health Care Fund, 564 N.W.2d 662, 664 (Wis. 1997). This, they assert, operates to deprive them of due process of law. *Id.*

Procedural Due Process analysis arguably differs from substantive Due Process analysis. For procedural Due Process, courts generally use a balancing test to evaluate the constitutionality of medical malpractice statutes of limitation, looking to see if the statute provides the appropriate balance between the state's interests and the plaintiff's right to pursue his or her claim. *Id.* at 485 (citing Mathews v. Eldridge, 424 U.S. 319 (1976)). The success of a procedural Due Process challenge generally depends on the court's interpretation of two factors: whether the plaintiff had a vested right in his or her cause of action, and whether the court finds the state's interest served by the statute to be reasonable. *Id.* at 478-79. Evaluations of the latter element often resemble the analysis for substantive Due Process. *Id.*

229. Dasha v. Maine Med. Ctr., 418 F. Supp. at 27 (emphasis omitted).

230. *Id.*

231. *Id.* at 28.

to section 2902, the question of whether occurrence-based accrual actually contributes to the purpose for which it was enacted is unlikely to receive meaningful judicial consideration. This Article asserts that the interest the legislature intended to benefit through enactment of section 2902 was the availability of quality, affordable health services in Maine.[232] It based adoption of section 2902 (as well as other tort reform measures) on the hypothesis that elimination of the discovery rule in all but foreign-object surgical cases would help decrease medical malpractice litigation costs in Maine. This, it was argued, would in turn lead to lower malpractice insurance premiums for physicians. And finally, lower premiums for the doctors would serve to minimize health care costs and to ensure that safe and affordable medical care was available to Maine's citizens. Given the interests at issue, both for individual medical error victims and all Maine citizens, it is unacceptable to allow the question of whether section 2902 contributes to this goal to go unexamined.

When application of section 2902 to latent misdiagnosis claims is scrutinized, the argument that it serves the above-stated goal is undermined at several levels. First, as stated in a comprehensive study conducted in 1989, it is not clear that there ever was a medical malpractice litigation-insurance crisis in Maine. In the *Final Report: Medical Malpractice Liability Study* [the *Liability Study*] independent research commissioned by the Legislature acknowledged that malpractice insurance premiums in Maine had risen during the previous ten years.[233] The authors, however, found that the increases were not decisively linked to corresponding increases in claim frequency or severity.[234] They cited insurer practices, including the use of reinsurance as significant contributors to the problem.[235]

On the issue of access to necessary services, the *Liability Study* researchers acknowledged that the number of family physicians willing to offer obstetrical services was declining.[236] At the time of the study, however, the effect was primarily limited to urban areas of the state[237] where these services were provided in other clinical settings.[238] The study also implicated decreased Medicaid reimbursement.[239] The authors concluded that:

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232. Quality health care is defined by the Institute of Medicine as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Frances H. Miller, *Medical Malpractice: External Influences and Controls: Medical Discipline in the Twenty-First Century: Are Purchasers the Answer*, 60 LAW & CONTEMP. PROBS. 31, 32 n.6 (1997) (quoting 1 INST. OF MED., MEDICARE: A STRATEGY FOR QUALITY ASSURANCE 21 (1990)).

233. LIABILITY STUDY, *supra* note 64, at 2.

234. *Id.* at 3.

235. In order to protect themselves against potential loss, liability insurance companies may purchase "reinsurance"—essentially paying a premium to have a reinsurer assume the risk of liability for a certain percentage of its policies. INSURING JUSTICE, *supra* note 10, at 15. The *Medical Malpractice Liability Study* authors found that "[f]orty percent of the premiums collected by [the state's dominant malpractice insurer] goes to cover the cost of reinsurance." LIABILITY STUDY, *supra* note 64, at 3.

236. *Id.* at 27.

237. The study, however, warned that "a serious decline in physicians available to treat obstetrical patients in rural areas may still come if insurance premium rates continue to climb." *Id.*

238. *Id.* at 4 (noting that "obstetrical services are available at hospital-based clinics and in family practice residencies").

239. *Id.* at 4-5 ("If insurance rates continue to climb and Medicaid fees remain below market prices, more Family Physicians are likely to drop obstetrics leaving a serious access problem for Medicaid recipients.").

> [I]t cannot be demonstrated that Maine faces a medical care "crisis" in availability and access to medical care due to rising medical malpractice insurance premiums. It can be demonstrated that Medicaid patients have increasingly limited options for their obstetrical care and this is due in part to the inadequacy of reimbursement fees for these services.[240]

Even if one looks past the conclusions of the *Liability Study* authors in order to accept the argument that the rise in medical malpractice insurance premiums negatively impacted the availability and affordability of health care in Maine, the question still remains: Do medical malpractice tort reforms and occurrence-based statutes of limitation in particular help alleviate this problem? The most recent assessment of Health Security Act reforms was presented in a study prepared for the Maine Bureau of Insurance: *Evaluation of Medical Malpractice Tort Reform.*[241] The study was conducted to gauge the effects of only two specific provisions, the collateral source rule and the liability demonstration project.[242] Despite its narrow focus, the information gathered pertains to tort reforms in general, including the statute of limitations. Reviewing claims gathered by the Bureau of Insurance between 1987 and 1999, the data, although indicating a gradual decline in the frequency of claim filings, demonstrated wide variability from year to year.[243] Examining claim severity, the data showed an overall increase in the size of the average amount paid per claim.[244] Again, however, the data showed an erratic pattern.[245] Regarding average loss cost,[246] the data was most notable for its fluctuations, with no predictable pattern discernable.[247]

The study's authors next attempted to assess adjustments made by insurers in medical malpractice premium rates during this time period.[248] Aggregate insurance rates for malpractice coverage for years 1994-1999 were listed, depicting some gradual decline.[249] The study was inconclusive, however, on the issue of which, if any, tort reforms had contributed to the decrease in insurance costs.[250] It did not address the issues of quality or availability of care.[251]

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240. *Id.* at 27.

241. EVALUATION, *supra* note 90.

242. For an explanation of these reform measures, see *supra* notes 90, 111.

243. EVALUATION, *supra* note 90, at 9.

244. *Id.* at 10.

245. *Id.*

246. "Loss cost " is defined by the study's authors as "the number of claims reported [combined] with the average cost per reported claim." *Id.* at 11.

247. *Id.* These conclusions are drawn from graphed data presented in the study and interpreted by the Author of this Comment.

248. *Id.* at 14.

249. *Id.* at 4.

250. *See id.* at 15-17. As part of their investigation, researchers reviewed correspondence between the Insurance Bureau and the two major malpractice carriers in Maine. *Id.* at 15. Initially defending a decision not to decrease premiums in 1993, one leading carrier, Medical Mutual Insurance Company of Maine (MMIC), itself questioned the ability of tort reforms to affect claim severity or frequency: "[W]e did not adjust the rate indications for the law evaluation in our ratemaking for several reasons. . . . The MMIC physician Board members and their legal counsel do not believe the changes will have a material impact on rates." *Id.* at 16. The Insurance Bureau asserted that the reforms were likely to result in savings, and these savings should be incorporated into the malpractice rates charged to physicians. *Id.* The Bureau estimated that the application of the statute of limitations to all claims would result in a savings of 1.0 percent of total malpractice costs. *Id.*

251. *See generally id.*

Drucilla K. Barker presented a more comprehensive analysis of effects from specific tort reforms in her 1992 article, *The Effects of Tort Reform on Medical Malpractice Insurance Markets: An Empirical Analysis*.[252] Barker utilized multi-state data in order to find out how "tort reform [has] affected relative prices and profitability in the medical malpractice insurance industry, and . . . how has it affected underwriting risk."[253] She reviewed Patricia Danzon's 1986 findings regarding the effect of specific reforms on claim frequency and severity.[254] Notably, Danzon concluded that restrictions on statutes of limitation do have some impact on claim frequency.[255]

Barker next looked at states' loss ratio data between 1977 and 1986 "to assess empirically the manner in which tort reforms have affected the . . . prices of malpractice insurance and underwriting risk."[256] She operated on the hypothesis that "if tort reforms make it easier to predict what harms health care professionals will be responsible for and how large the resulting damages will be, then they will decrease underwriting risk."[257] As a result of this analysis, Barker found that "[t]he only tort reform that exhibits any consistent effect on total underwriting risk is a statutory ceiling on recovery."[258] She concluded that "tort reforms have not been as effective as their authors would have liked."[259] According to Barker, a broader approach to reform is necessary: "[T]he problems associated with medical malpractice insurance are numerous and complex . . . . They are part of the larger problem of how to minimize the incidence of accidental medical harm and, when such harm does occur, how at the same time to fairly and efficiently allocate the resulting losses."[260]

Thus, analysis indicates that in their totality, restrictions on the statute of limitations may decrease to some extent claim frequency in Maine, but not overall claim severity or loss cost. Because latent error malpractice claimants are but a subset of potential plaintiffs to whom the statute of limitations would apply, the effect on claim frequency from elimination of their rights is further diminished. Further, it is not clear whether any frequency that remains attributable to elimination of latent medical error claims translates to less risk for malpractice insurers. But even assuming that it does—the Maine Insurance Bureau projected that all applications of the new statute of limitations and the pre-litigation screening pan-

252. Drucilla K. Barker, *The Effects of Tort Reform on Medical Malpractice Insurance Markets: An Empirical Analysis*, 17 J. HEALTH POL. & L. 143 (1992).

253. *Id.* at 144. Underwriting risk "refers to the probability that the actual losses an insurer faces will be different from the expected losses." *Id.* at 145.

254. *Id.* at 144 (citing Patricia Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW & CONTEMP. PROBS. 115 (1986)).

255. *Id.* These conclusions were duplicated in a 1989 examination by other researchers. *Id.* (citing F. Sloan et al., *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis,* 14 J. HEALTH POLITICS & L. 663 (1989)). These studies showed, however, that "[t]he greatest savings were generated by dollar ceilings on recovery. . . . [C]eilings . . . significantly reduced the amount of payment and increased the speed with which a claim is resolved." *Id.*

256. *Id.* at 144-45.

257. *Id.* at 151.

258. *Id.* at 157.

259. *Id.* at 158.

260. *Id.* at 159.

els combined should result in a savings of only one percent[261]—and assuming that the savings would be passed on to premium holders,[262] the question persists as to whether these accomplishments translate into improved health care for Maine citizens.

Safety is an integral component of quality health care. No one expects to be harmed when they go to the doctor. And yet, every year in the United States hundreds of thousands of Americans are injured by mistakes that occur during the delivery of that health care.[263] One out of every two hundred people who are admitted to the hospital *die* as a result of such mistakes.[264] When every trip to the doctor has a significant chance of causing harm, health care is not safe. In addition to the human costs, economic losses from such adverse events are enormous, exceeding $30 billion each year.[265] Hospital medication errors alone cost the nation at least $2 billion annually.[266] In this environment of errors, the question is whether tort reforms—particularly those such as occurrence-based statutes of limitation that encourage nondisclosure of errors—have a net effect of improving access to safe and affordable care, or whether they act to diminish the quality of care.

For thousands of years civilized societies have developed health care systems to cure and care for their sick. These societies concurrently recognized that medical errors sometimes caused injury. In response, they created laws designed to minimize such occurrences and compensate victims.

The current model of malpractice litigation used in this country has been employed for over 1300 years, and until recently, it assigned blame, provided compensation, and deterred future negligence in a relatively efficient manner, maintaining at least a reasonable equilibrium. For the past several decades, however, the system has faltered. Critics argue that the parties most often held legally ac-

261. EVALUATION, *supra* note 90, at 16. Relying on the Insurance Board's estimation of a one percent savings, the actual savings in dollars attributable to section 2902 appear to be modest. In 1994, medical malpractice premiums charged to Maine physicians cumulatively totaled approximately $31 million. *Id.* at 4. Applying the Insurance Bureau's estimate of a one percent savings from all applications of the statute of limitations and the pre-litigation screen panels, these measures combined would result in a net savings of approximately $310,000. Assuming for arguments sake that section 2902 produces one-half of this premium reduction, the annual savings attributable to the measure drops to $155,000. As a subset of malpractice cases thwarted by the statute of limitations, latent error malpractice claims would account for only a fraction of that $155,000.00 yearly savings, perhaps much less than half.

262. This assumption does not take into account the effects of section 6305 of title 24 of the Maine Revised Statutes, which requires that a portion of "the amount of the savings in professional liability insurance claims and claim settlement costs to insurers anticipated in each 12-month period as a result of the Medical Liability Demonstration Project . . . and reform of the collateral source rule" are to be used to fund the Rural Medical Access Program. ME. REV. STAT. ANN. tit. 24-A, § 6305 (West 2000). The program was adopted in 1989 and is designed to provide assistance with medical malpractice insurance costs to physicians who provide obstetrical care to Medicaid patients in underserved areas of the state. *Id.* §§ 6301-11.

263. *See supra* note 1 and accompanying text.

264. Gerlin, *supra* note 1, at A1.

265. *See* INSTITUTE OF MEDICINE, *supra* note 1, at 22, 34-35. By contrast, malpractice insurance costs total approximately $9 billion annually. *See* Paul C. Weiler, *The Case for No-Fault Medical Liability*, 52 MD. L. REV. 908, 909 (1993).

266. INSTITUTE OF MEDICINE, *supra* note 1, at 35. In outpatient settings, one study estimated that medication related errors in 1994 resulted in economic losses to the nation approximating $76.6 billion. *Id.* Research conducted for the Institute of Medicine determined that medication errors alone are responsible for 100,000 deaths each year in the United States, more than automobile accidents, AIDS, or breast cancer. Alan C. Horowitz, *Nonpunitive Medication Error Reporting Systems*, HEALTH LAW NEWS, March 2000, at 6.

countable, physicians and other primary providers, are unfairly prosecuted because most injuries occur due to circumstances beyond their control.[267] As a result, they claim, physicians conduct their professional lives in fear of litigation. [268]

Prior to the twentieth century, health care was delivered by individual practioners, often within patients' homes. The medical care thus provided was usually simple, palliative, and administered either directly by the physician or by the patient's family members acting at the physician's direction.[269] Even medications were normally dispensed by the doctors themselves. In this health care delivery system, the physician controlled virtually all aspects of the medical care provided to patients. Thus, the physician could rightly be held accountable for medical errors, and was well placed to effectuate the changes necessary to prevent their recurrence.

In contrast to earlier practices, modern health care is technological, invasive, and capable of causing great harm as well as tremendous good. It is delivered to patients in offices, clinics, and hospitals via complex systems made up of many providers and support personnel. Even simple tests and procedures involve multiple technologies and individuals, each performing segmented, interdependent tasks. Because of the nature of modern health care, and because the chain of delivery contains numerous individuals and variables, opportunities for serious error increase. Further, when negligent error occurs, accurately assigning blame to a single individual is often not possible.[270]

In the recent past, as the rate of medical injury continued to rise, many in both government and health care referred to medical errors as the inherent risks of practicing medicine, implying that such occurrences could not be prevented and should be accepted. Inherent risk, however, is not particular to health care. Other industries have faced the problems generated by technology and complex service delivery issues, and they have refused to simply accept a high rate of error and injury. They instead have successfully designed systems to prevent those errors.[271] Dr. Lucian Leape, one of the authors of the landmark Harvard Study, examined the airline industry as a possible model for error prevention.[272] He noted similarities between the two industries. Both involve the administration of services to customers in an environment that requires simultaneous attention to multiple tasks that are often technical in nature. Both require those consumers to rely completely on the providers to ensure their safety while they are in the system. And in both settings, the consequences for even small errors may be grave.[273] Compared to

267. *See* Lucian Leape, *Error in Medicine*, 272 J. AM. MED. ASS'N. 1851, 1854 (1994) [hereinafter Leape, *Error*].

268. *Id.* at 1852.

269. *See supra* Part II.

270. *See* Leape, *Error*, *supra* note 267, at 1852. Dr. Leape concluded, based on his own research and that of other experts in error analysis, that the causes of most negligent medical errors are beyond the control of the individual who is unfortunate enough to be the proximate error, or proximate cause of the injury. *Id.* "All humans err frequently. Systems that rely on error–free performance are doomed to fail." *Id.* Leape also points out that the "medical approach to error is reactive." *Id.* Further, these responses to error tend to focus only on the performance of the individual who was the proximate cause of the error, attempting to prevent *that* person from making the same error again. *Id.* Such an approach, Leape points out, fails to address the underlying causes of medical errors and injuries, and the error is likely to recur. *Id.*

271. *See* INSTITUTE OF MEDICINE, *supra* note 1, at 137.

272. *See* Leape, *Error*, *supra* note 267, at 1855.

273. *See id.* (citing M.F. Allnutt, *Human Factors in Accidents*, 59 BRIT. J. ANESTH. 856 (1987)).

health care, however, the commercial airline industry has an enviable safety record: out of ten million take-offs and landings each year, it averages only four crashes.[274]

The impetus for safety systems in the aviation industry initially came from pilots, who were themselves endangered by poorly designed systems and working environments. Since that time, the industry has comprehensively approached the problem by assuming that human error and mechanical failures are inevitable. Systems are designed with levels of redundancy to harmlessly absorb these errors. Additionally, work environments are designed to minimize the chances for human error. Further, procedures are standardized to the extent possible (e.g., pilot checklists). Training and certification requirements, as well as frequent recertification (every six months) requirements are rigidly enforced.[275] Significantly, the federal government maintains two separate agencies that deal only with safety in aviation.[276] There is also a federally funded confidential error reporting system, the results of which are routinely analyzed and published in aviation trade journals.[277]

Critics of the comparison drawn between aviation and medicine point out that the two industries are fundamentally different in at least one important respect. In medicine, a certain amount of risk taking is desirable and even necessary if advances in treatment are to occur. In aviation, however, risk that affects consumers is never desirable. Despite this, one specialty area in medicine, anesthesia, has drawn on the aviation model in order to proactively address the problem of medical error.[278]

In the 1980s, the rate of adverse events occurring in patients undergoing anesthesia was alarming: the mortality rate was between 1 per 10,000 and 1 per 20,000 patient procedures.[279] Motivated by high malpractice costs and a desire to improve care, anesthesiologists at Harvard studied the types of error that were occurring and developed systems that make it more difficult for such errors to occur. By 1994, the mortality rate from anesthesia related procedures had dropped to one per 200,000, one-tenth to one-twentieth of what it was less than a decade before.[280]

In January of 2000, the Federal Government, calling attention to both the threat to public health presented by medical error and the existence of a means to effectuate positive change, announced a program aimed at decreasing the incidence of preventable medical error by fifty percent over the next five years.[281] The pro-

274. *See id.*

275. *Id.*

276. *Id.*

277. *Id. see also* TO ERR IS HUMAN, *supra* note 1, at 82-83.

278. Leape, *Error*, *supra* note 267, at 1856.

279. *See* Patrice L. Spath, *Reducing Errors Through Work System Improvements*, *in* ERROR REDUCTION IN HEALTH CARE, 200 (Patrice L. Spath ed., 1999).

280. *Id.*; *see also* Leape, *Error*, *supra* note 267, at 1856.

281. *See* INSTITUTE OF MEDICINE, *supra* note 1, at 5. The program has four primary areas of emphasis. These are as follows:

> [1. E]stablishing a national focus to create leadership, research, tools and protocols to enhance the knowledge base about safety;
>
> [2. I]dentifying and learning from errors through the immediate and strong mandatory reporting efforts, as well as the encouragement of voluntary efforts, both with the aim of making sure the system continues to be made safer for patients;
>
> [3. R]aising standards and expectations for improvements in safety through the actions of oversight organizations, group purchasers, and professional groups;
>
> [4. C]reating safety systems inside health care organizations through the implementation of safe practices at the delivery level. This level is the ultimate target of all the recommendations.

Id.

posed changes are based on the results of research conducted by the Institute of Medicine.[282] They are broadly directed toward individual and institutional care providers, as well as state governments. They focus on the need for comprehensive state-based error tracking mechanisms,[283] and advocate for fundamental changes within the medical and legal systems in order to prevent the majority of medical errors, injuries, and their resulting costs.[284]

VII. Conclusion

Recognizing that the Maine Legislature enacted section 2902, as well as the other litigation related provisions of the Maine Health Security Act, to further the state's interest in the health and welfare of its citizens, this Comment argues that, in cases of latent injury or misdiagnosis where the negligent error and injury remain undiscoverable during the statutory period, the occurrence-based accrual provision of the statute of limitations for medical malpractice works an unnecessary injustice. This Comment recommends that the Legislature amend the statute to permit application of the discovery rule to such cases. This Comment further recommends that the Maine Legislature reassess the litigation provisions included in the Maine Health Security Act, and adopt a policy oriented at every level toward identifying the causes of medical injuries and minimizing their occurrence, and toward compensating all victims of medical error for their actual losses to the degree the system will allow.

Virtually every citizen in Maine, at some point, must place his or her faith in the health care system. At the present time, however, when we do so we face a real risk of injury. Patients afflicted with latent diseases, such as cancer, suffer some of the most devastating such injuries. Because of the insidious nature of their illnesses, patients who suffer latent medical errors related to misdiagnosis may remain unaware of their true condition and need for treatment for years. Unarguably, the right of these blameless individuals to seek compensation should not be taken away unless doing so is clearly necessary and serves a greater good.

When a statutory system of litigation, or the application of a provision within it, infringes on individual's legal rights while at the same time failing to provide a public benefit, it should be repealed. As applied to latent injury plaintiffs, the occurrence-based accrual provision of section 2902 eliminates the right to seek relief in the courts. At the same time, it fails both as an individual provision and as part of a medical malpractice litigation system that does not deter the occurrence of most medical errors and injury and their costs.

With the research and models now available, Maine has an opportunity to decrease occurrences of medical error and injury. Accomplishing this, however, will require redesigning the present medical malpractice system: focusing efforts and evaluating proposals based on their ability to contribute to ensuring the availability of safe and affordable health care, and guaranteeing that those injured by medical error receive reasonable compensation for their injury.

Kathy Kendall

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282. *See generally*, INSTITUTE OF MEDICINE, *supra* note 1.

283. President Clinton called for mandatory reporting of all "serious" medical errors. *See* Videotape: President Clinton: Medical Errors, Statement of President Clinton (C-span 2, recorded Feb. 22, 2000) (on file with the author).

284. *See* INSTITUTE OF MEDICINE, *supra* note 1, at 3 ("[T]here is a need to enhance knowledge and tools to improve safety and break down legal and cultural barriers that impede safety improvement.").