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Maine Physician Practice Guidelines: Implications for Medical Malpractice Litigation

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MAINE PHYSICIAN PRACTICE
GUIDELINES: IMPLICATIONS FOR
MEDICAL MALPRACTICE LITIGATION

Jennifer Begel

I. INTRODUCTION 70

II. BACKGROUND 72

III. IMPLICATIONS OF THE MAINE LEGISLATION..... 80

 A. *Potential for Success of the Affirmative Defense* 81

 B. *Inherent Obstacles Presented by the Prelitigation
 Screening Panel Provisions* 81

 1. *An Affirmative Defense at the Panel Stage* 82

 2. *The Affirmative Defense in Summary Judgment
 Proceedings* 83

 C. *Inherent Shortcomings in the Practice Guidelines
 Statutory Scheme*..... 85

 1. *Exculpatory Use of the Evidence of Compliance
 with Guidelines*..... 86

 2. *The Non-Exclusive Findings Regarding
 Compliance with Guidelines* 87

 3. *Use of Experts* 88

IV. POTENTIAL CONSTITUTIONAL CHALLENGES TO THE
 LEGISLATION 88

 A. *Resolution of the Affirmative Defense by the
 Panel* 89

 1. *Usurpation of a Judicial Function*..... 90

 2. *Right to Trial by Jury* 91

 B. *Use of Evidence by Defendants Only*..... 93

 1. *Challenges to the Legislation on Equal Protection
 Grounds* 93

 2. *Challenges to the Legislation on Due Process
 Grounds* 98

VI. CONCLUSION..... 101

MAINE PHYSICIAN PRACTICE GUIDELINES: IMPLICATIONS FOR MEDICAL MALPRACTICE LITIGATION

Jennifer Begel*

I. INTRODUCTION

The current debate over health care reform has seized the attention of the American public and has spawned proposals affecting virtually every aspect of health care delivery. Perceived as at least a minor cause of the growth in health care expenditures over the last decade,¹ medical malpractice litigation has been targeted as one area in need of reform. President Clinton's health care package recommends significant changes to medical malpractice litigation procedures and expressly promotes adopting such approaches as the "program in Maine that frees doctors from malpractice liability if they can demonstrate that they followed prescribed clinical practice guidelines."² The President's report of his plan to the American people explains that under a system, like Maine's, using physician practice guidelines, a physician cannot be held liable for malpractice if the physician demonstrates compliance with the appropriate guidelines.³

This Article assesses the use of physician practice guidelines as a vehicle for medical malpractice tort reform and focuses upon the State of Maine's legislation incorporating physician practice parameters into the defense of medical malpractice litigation. The Maine Medical Liability Demonstration Project⁴ (the "Demonstration Project") legislatively adopts practice guidelines in four different medical specialties and allows physicians in those specialties to assert

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1. Health expenditures rose at a rate of 12% annually between 1966-1977, from \$42 billion to \$82 billion. Cathy Firshein and Janet Tokarski, *Curbing Health Costs: Many Tried, None Succeeded*, A NEW DEAL FOR AMERICAN HEALTH CARE: HOW REFORM WILL RESHAPE HEALTH CARE DELIVERY AND PAYMENT FOR A NEW CENTURY 167 (Richard M. Sorian et al. eds., 1993). By 1988, spending reached \$547 billion. The 1993 spending figure was \$942 billion. The U.S. Commerce Department estimates that expenditures will climb to \$1.06 trillion in 1994. THE 1994 U.S. COMMERCE DEPARTMENT INDUSTRIAL OUTLOOK.

2. WHITE HOUSE DOMESTIC POLICY COUNCIL, THE PRESIDENT'S HEALTH SECURITY PLAN 91 (Times Books ed. 1993).

3. *Id.*

4. ME. REV. STAT. ANN. tit. 24, §§ 2971-79 (West Supp. 1993-1994).

compliance with the applicable guideline as an affirmative defense.⁵ The affirmative defense of compliance with such guidelines has been touted as a means of protecting physicians from, and decreasing the costs associated with, medical malpractice litigation.⁶ While the statutory mechanism remains untested, analysis of the legislation reveals the practical implications and limitations of the enactment.

Only in a very narrow window of cases will the statute, particularly the affirmative defense of compliance, be advantageous to physician-defendants in reducing (but not completely eliminating) the length and complexity of a medical malpractice suit. Notwithstanding the laudable goals underlying the legislative guidelines, success will be thwarted by two significant obstacles. First, the entire legislative scheme for guidelines was designed without consideration of the implications presented by the requirements of Maine's mandatory prelitigation screening panel for medical malpractice cases. Imposition of these screening criteria on the practice guidelines' statutory framework almost entirely undermines any hope of avoiding the lengthy procedures associated with the defense of a medical malpractice suit. Second, the legislation suffers from two potential constitutional infirmities: denying plaintiffs the right to a jury trial and denying plaintiffs the use of evidence regarding guidelines. This Article reviews both the practical procedural effects and the constitutional issues triggered by the legislation.

This Article begins with a brief survey of the efforts taken by jurisdictions across the country to combat rising medical malpractice costs, the emergence of reforms such as prelitigation screening panels, and ultimately, the use of physician practice guidelines. An explanation of the manner in which the physician practice guidelines came to be incorporated into legislation, as well as their interrelationship with Maine's prelitigation screening panel enactment, is included in the second section. This section of the Article explains the mechanics of Maine's prelitigation screening panel process, setting the backdrop for illustrating the practical implications of the guidelines legislation.

In the third section of this Article a hypothetical scenario in which an anesthesiologist is sued for allegedly failing to appropriately monitor a patient is used to highlight the procedural requirements and evidentiary issues triggered by the assertion of the affirmative defense of compliance. The same hypothetical is used to explain why this affirmative defense can reasonably be expected to curtail litigation in only a narrow window of cases. The third section also

5. Legis. Rec. H756-57 (1990) (statement of Rep. Rydell). *See also* GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: MAINE'S USE OF PRACTICE GUIDELINES TO REDUCE COSTS 4 (1993) [hereinafter GAO REPORT].

6. *Id.*

addresses the anticipated factual assertions that will likely undermine any summary judgment attempts.

In the fourth section of this Article, certain inherent shortcomings in the practice guidelines' statutory scheme are reviewed. An analysis of these shortcomings, like the factual assertions that will undermine summary judgment efforts, illustrates why the guidelines fall short of achieving their desired results. Specifically, this Article asserts that procedural difficulties will arise because: (1) the prelitigation panel proceedings may generate a loophole through which inculpatory evidence regarding inappropriate adherence to practice guidelines may be presented to a jury; (2) a finding of compliance with an applicable practice guideline is not necessarily conclusive on the issue of negligence, especially in the context of the prelitigation panel proceedings; and (3) the affirmative defense of compliance may not obviate the need for expert testimony on the standard of care issue at either the panel or trial level.

The final section of this Article discusses certain constitutional infirmities that may invalidate the Maine Demonstration Project. First, the legislation contains a provision that makes evidence regarding compliance with an applicable guideline available to defendant physicians but not to plaintiffs. A court analyzing the rationale and the effects of this provision might conclude that it is unconstitutional and invalid. Another problematic aspect of the legislation arises from the fact that, in order to integrate the guidelines legislation and the prelitigation screening panel provisions, the screening provisions were amended after the enactment of the guidelines legislation to confer upon the screening panel the authority to resolve the affirmative defense of compliance with the guidelines. If this provision is construed to bestow upon the panel the authority to make determinations as a matter of law, thereby divesting plaintiffs of the right of access to both the superior court and a jury, the entire scheme could be found unconstitutional.

The Article concludes with suggestions regarding how the Maine legislation might be amended to address its procedural and constitutional shortcomings.

II. BACKGROUND

The emergence of physician practice guidelines as a means of curtailing medical malpractice litigation followed a series of national legislative efforts at medical care reform. Beginning in the 1970s, a number of states began enacting comprehensive legislative reform packages to combat what was perceived as a medical malpractice crisis.⁷ Physicians and insurance providers declared a "malpractice

7. See, e.g., Neal A. Roth, *The Medical Malpractice Insurance Crisis: Its Causes, the Effects and Proposed Solutions*, 44 INS. COUNS. J. 469 (1977).

crisis" based on an increase in the number of medical malpractice claims and the growing size of the verdicts awarded by juries in malpractice cases.⁸ The approaches taken by the various states included legislation establishing medical malpractice damage limitations, some of which placed absolute limitations on the total recovery permitted to plaintiffs. Other approaches included statutes limiting the recovery of non-economic damages,⁹ legislative provisions establishing medical malpractice screening panels and revising applicable statutes of limitation, and the development of physician practice guidelines.¹⁰

The State of Maine was one of a number of jurisdictions to undertake the enactment of a statutory scheme requiring the submission of all medical malpractice cases to a prelitigation screening panel.¹¹

8. U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 13 (1973).

9. Analysis of the development and constitutionality of medical malpractice damage award caps is beyond the scope of this paper. For further information see generally Mary Ann Willis, *Limitation on Recovery of Damages in Medical Malpractice Cases: A Violation of Equal Protection?*, 54 U. CIN. L. REV. 1329 (1986).

10. Although the scope of this Comment is limited to analyzing the use of physician practice guidelines in the context of medical malpractice litigation, it is worth noting the growing criticism and doubt regarding physician practice guidelines in general. A resolution adopted at the American Medical Association's December 1992 semi-annual meeting stated that there is no evidence that guidelines have any impact on malpractice costs. See MEDICAL OUTCOMES AND GUIDELINES SOURCE BOOK (Spencer Vibbert & John Reichard eds., 2d ed. 1993). Much concern has been expressed regarding the inconsistency and variability among guidelines emanating from different sources within the medical profession. See, e.g., Karen Sandrick, *Out in Front: Managed Care Helps Push Clinical Guidelines Forward*, HOSP., May 5, 1993 at 30.

In addition, practice guidelines opponents cite a lack of evidence to support the proposition that clinical practice guidelines actually improve care rendered to patients. There is some fear that guidelines will result in a lowering in the quality of care provided by clinicians whose hands may be tied from trying technologically advanced treatments. The same opponents argue that the physician guidelines cannot capture the nuances of individual patients' circumstances and simply fall short of providing any real guidance to most clinical situations. See David L. Schriger et al., *The Origins, Benefits, Harms and Implications of Emergency Medicine Clinical Policies*, 22 ANNALS OF EMERGENCY MED. 597, 599 (1993). Moreover, many are concerned that physicians will place too much reliance on guidelines and ultimately lose their capacity to deal with unique situations which commonly arise in the practice of medicine. *Id.* A different viewpoint argues that the guidelines may compromise the ethical status of the doctor-patient relationship. See John E. Wennberg, *Unwanted Variations in the Rules of Practice*, 265 JAMA 1306, 1307 (1991). The scientific validity of guidelines, including the methods by which they have been formulated, has been criticized. It has been argued that guidelines have the potential to create "cookbook medicine," thus reducing the "art" of medicine. See Stephen M. Merz, *Clinical Practice Guidelines: Policy Issues and Legal Implications*, 19 THE JOINT COMM'N J. ON QUALITY IMPROVEMENT 306, 307 (1993). Nonetheless, the number and scope of practice guidelines have increased significantly in recent years.

11. ME. REV. STAT. ANN. tit. 24, §§ 2851-2859 (West 1990 & Supp. 1993-1994).

Review of the mechanics and implications of this legislation clarifies the impact of physician practice guidelines on medical malpractice litigation. The purpose of the legislation, effective January 1, 1987, is:

- A. To identify claims of professional negligence which merit compensation and to encourage early resolution of those claims prior to commencement of a lawsuit; and
- B. To identify claims of professional negligence and to encourage early withdrawal or dismissal of nonmeritorious claims.¹²

Significantly, the panel process is mandatory unless waived by all parties to an action.

To initiate any action against a health care provider, the prelitigation screening panel enactment requires the filing of a notice of claim, rather than a complaint.¹³ The effect of this notice, served upon the physician-defendant, is to stay the applicable statute of limitations and to begin the running of the 180-day period within which the panel is to convene, decide the merits of the claim, and issue its findings.

During the panel process, full discovery is permitted.¹⁴ All discovery, including the notice of claim itself, depositions, and interrogatories, is protected from public disclosure and is entirely confidential. At the close of discovery, a hearing is convened before the designated panel. The panel is made up of a retired judge,¹⁵ an attorney, and, if possible, a medical practitioner in the same specialty as the defendant.¹⁶ The panel is charged with determining: (1) whether the acts complained of constitute a deviation from the applicable standard of care by the health care practitioner; (2) whether the acts complained of proximately caused the plaintiff's injury; and (3) if the health care practitioner was negligent, whether any negligence by the patient was equal to or greater than the negligence of the health care provider.¹⁷ One of the curious aspects of the panel process, especially when considered in light of the legislation's purpose, is the effect given to the panel's ultimate conclusions. If the panel unanimously finds that the health care practitioner was negligent and proximately caused the plaintiff's injuries, the fact of

12. ME. REV. STAT. ANN. tit. 24, § 2851(1) (West 1990 & Supp. 1993-1994).

13. ME. REV. STAT. ANN. tit. 24, § 2853(1) (West 1990).

14. ME. REV. STAT. ANN. tit. 24, §§ 2853(4), 2857(3) (West 1990 & Supp. 1993-1994).

15. According to the legislation as initially passed, the chairperson was intended to be a retired justice of the superior court. Due to the small number of retired justices in Maine, however, and to the resulting delay in the screening panel process, the chairperson may now be any member of the bar appointed by the Chief Justice of the Superior Court and approved by the parties to the action.

16. ME. REV. STAT. ANN. tit. 24, § 2852(2) (West 1990 & Supp. 1993-1994).

17. ME. REV. STAT. ANN. tit. 24, § 2855(1) (West 1990 & Supp. 1993-1994).

the panel and its findings are admissible in a subsequent trial before a jury. In comparison, a non-unanimous finding is not admissible in any manner in a subsequent trial. Regardless of the result at the panel level, a plaintiff may proceed to trial.

The prelitigation screening panel process incorporates several traditional standards of medical malpractice actions, including placing the burden on the plaintiff to prove by expert medical testimony (1) the appropriate standard of medical care; (2) that the defendant departed from that recognized standard; and (3) that the conduct in violation of the standard was the proximate cause of the plaintiff's injury.¹⁸ The medical practitioner is held to a national standard of care.¹⁹

The enactment of Maine's prelitigation screening panel legislation coincided with a number of other developments in the realm of health care cost containment. Such developments included certain research results regarding outcomes and variations in physician practices,²⁰ as well as a growing concern with regard to increasing malpractice litigation and associated costs. These forces influenced a movement encouraging the development of physician practice parameters, which was motivated at least in part by the belief that properly constructed practice guidelines could eliminate inappropriate treatment, thereby decreasing the cost of medical care.²¹ These "parameters," or clinical practice guidelines, have been defined as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for a specific clinical

18. See *Cox v. Delacruz*, 406 A.2d 620, 622 (Me. 1979) (judgment n.o.v. for physician-defendant upheld due to plaintiff's failure to produce expert testimony in regard to standard of care and deviation from it). See also *Caron v. Pratt*, 336 A.2d 856, 860 (Me. 1975).

19. See *Taylor v. Hill*, 464 A.2d 938, 943 (Me. 1983) (when a physician holds himself out as a specialist, he is held to the same standard of care of all physicians in that specialty). See also *Hall v. Hilburn*, 466 So.2d 856, 873 (Miss. 1985).

20. See M. R. Chassin et al., *Variations in the Use of Medical and Surgical Services by the Medicare Population*, 314 NEW ENG. J. MED. 285 (1986). See also Troyen A. Brennan, *Practice Guidelines and Malpractice Litigation: Collision or Cohesion?*, 16 J. HEALTH POL., POL'Y & L. 67 (1991) (citations omitted).

21. Schriger, *supra* note 10, at 598. It is worth noting, however, that although the claim has been made that the American Society of Anesthesiologists Guidelines for monitoring general anesthesia has "prevented the occurrence of hypoxic brain damage" and has "led to a reduction of malpractice premiums for anesthesiologists," Matthew Liang, *From America: Cookbook Medicine of Food for Thought: Practice Guidelines Development in the U.S.A.*, 51 ANNALS OF RHEUMATOLOGY DISPATCH 1257 (1992), the actual reduction in overall national anesthesiology insurance rates has not been clearly shown. In Maine, a half percent reduction in one insurance carrier's premiums was ordered by the Insurance Commission in 1992, a direct result of the Demonstration Project and related practice guidelines. Interview with Gordon Smith, Maine Hospital Association Counsel, in Augusta, Me. (Mar. 31, 1994).

circumstance,"²² and have generally been "intended to serve as tools by which scientifically valid and reliable standards of clinical practice can be implemented."²³ Use of guidelines has been viewed as a means of reducing the practice of "defensive medicine"²⁴ as well as a means of decreasing variation in medical care by educating physicians about processes demonstrated to have satisfactory outcomes.

The State of Maine embraced the philosophy that physician practice guidelines were a means worth pursuing toward the ends of high quality health care and cost reduction. In a pioneering effort, a coalition formed for the single purpose of designing a plan to achieve this goal drafted a proposal known as the Medical Liability Demonstration Project.²⁵ The Demonstration Project included a legislative scheme incorporating physician practice guidelines into Maine's medical malpractice litigation proceedings, and required the establishment of "risk management protocols . . . designed to avoid malpractice claims and increase the defensibility of the malpractice claims that are pursued."²⁶

As proposed, the guidelines legislation provided that physicians would be granted immunity from suit upon a showing of compliance with the approved guidelines. The final version of the project was

22. Robert S. A. Hayward et al., *More Informative Abstracts of Articles Describing Clinical Practice Guidelines*, 118 ANNALS OF INTERNAL MED. 731 (1993) (citation omitted).

23. Brian S. Mittman et al., *Implementing Clinical Practice Guidelines: Social Influence Strategies and Practitioner Behavior Change*, QUARTERLY REV. BULL. 413 (Dec. 1992).

24. Some doubt has been cast on the view that the practice of defensive medicine, allegedly attributable to fears of malpractice litigation, is a significant factor in the rising cost of health care. The most widely cited estimate attributed only 1% of medical expenditures in 1984 to defensive medicine. Roger A. Reynolds et al., *The Cost of Medical Professional Liability*, 257 JAMA 2776 (1987). One expert has stated that "even if defensive medicine were zero in 1940, its growth can only account for a trivial fraction of the expenditure increase." J. Newhouse, *Medical Care Costs: How Much Welfare Loss?*, 6 J. OF ECON. PERSP. 3 (1992). Another has opined that if the system of medical malpractice law were restructured, "much of defensive medicine would probably still be provided for reasons other than concerns about malpractice." CONGRESSIONAL BUDGET OFFICE, PROJECTIONS OF NATIONAL HEALTH EXPENDITURES 12 (1992); *President's Proposal on Health Care Reform and the Fiscal Year 1993 Health and Human Services Budget: Hearings Before House Committee on Ways and Means*, 102nd Cong., 2d Sess. 300, 335-38 (1992) (citing testimony of Robert D. Reischauer, Director, Congressional Budget Office). Despite these and other similar assessments, medical malpractice tort reform, including steps designed to curtail "defensive medicine," has been proposed and implemented on both the state and national level.

25. ME. REV. STAT. ANN. tit. 24, §§ 2971-79 (West Supp. 1993-1994). The Demonstration Project was actually only one portion of a medical malpractice tort reform package that included a "collateral source rule" provision, amendments to certain medical malpractice discovery rules, and the establishment of a rural access initiative involving funding for obstetrics physicians in rural areas. L.D. 2513 (114th Legis. 1990).

26. ME. REV. STAT. ANN. tit. 24, § 2973 (West Supp. 1993-1994).

adopted by the Legislature in the early morning hours of the closing 1990 legislative session and was the subject of little discussion.²⁷ Introduction to consideration of the bill included the explanation that three medical specialties would be responsible for developing practice parameters which were to "be designed to help avoid future malpractice claims and to decrease the cost of defensive medicine"²⁸ and "help to reduce the costly battle with experts that often occurs in malpractice cases."²⁹ In addition, it was offered that a physician who elects to participate could introduce as *an affirmative defense* evidence of compliance with the protocols in the event that he or she should be sued in the future.³⁰ Although there is no legislative record reflecting the process and rationale that led to this result, the initially proposed immunity had been revised to an affirmative defense.³¹ It has been suggested that the Judiciary Committee, when presented with the initial immunity proposal, was simply not comfortable with such a concept.³² Presumably the Committee found insufficient justification for elevating physicians to the status of protected government officials, who enjoy at least qualified immunity from suit.

The practice guidelines enactment, as passed, provides (in pertinent part):

In any claim for professional negligence against a physician or the employer of a physician . . . in which a violation of a standard of care is alleged, only the physician or the physician's employer may introduce into evidence, *as an affirmative defense*, the existence of the practice parameters and risk management protocols developed and adopted pursuant to § 2973 for that medical specialty area.³³

The enactment also states: "Any physician or physician's employer who pleads compliance with the practice parameters . . . as an affirmative defense to a claim for professional negligence has the burden of proving that the physician's conduct was consistent with those parameters"³⁴

27. Significant debate focused on the section of the bill regarding the collateral source rule and on the fact that the final version of the bill lacked a cap on the recoverable damages allowed in medical malpractice cases. Legis. Rec. H756-70 (1990).

28. *Id.* at 756.

29. *Id.*

30. *Id.* (emphasis added).

31. Notwithstanding the lack of such a provision in the legislation, some public misperception apparently exists that the enactment does provide immunity. See, e.g., Merz, *supra* note 10, at 308.

32. Interview with Gordon Smith, Maine Hospital Association Counsel, in Augusta, Me. (Mar. 15, 1994).

33. ME. REV. STAT. ANN. tit. 24, § 2975(1) (West Supp. 1993-1994) (emphasis added).

34. ME. REV. STAT. ANN. tit. 24, § 2975(2) (West Supp. 1993-1994).

Practice guidelines adopted by the specific medical specialties involved in the Maine Demonstration Project share the same fundamental goals as practice guidelines followed in other states. These include addressing the escalating costs of health care,³⁵ reducing the practice of defensive medicine,³⁶ curtailing conflicting expert testimony in medical malpractice litigation,³⁷ and improving the quality of care provided to patients.³⁸

The Maine protocols were formulated with the belief that such guidelines would reduce any tendency by physicians to order tests and perform procedures strictly as a shield from potential malpractice suits. It was anticipated by participants in the Demonstration Project, as well as drafters of the legislation, that physicians following practice guidelines would be free to practice quality medicine without engaging in unnecessary, expensive procedures.³⁹

Maine's physician practice guidelines were the first in any jurisdiction designed with the specific intention of incorporation into medical malpractice legislation.⁴⁰ The guidelines referenced and adopted into the Maine statute⁴¹ are comprised of revised versions of the national standards of three medical specialties and their respective national organizations—the American Society of Anesthesiologists (ASA), the American College of Radiology (ACR), and the American College of Obstetricians and Gynecologists (ACOG).⁴² In addi-

35. Gordon H. Smith, *A Case Study in Progress: Practice Guidelines and the Affirmative Defense in Maine*, 19 THE JOINT COMM'N J. ON QUALITY IMPROVEMENT 356 (1993).

36. *Id.*

37. Brennan, *supra* note 20, at 73.

38. Marilyn J. Field, *Overview: Prospects and Options for Local and National Guidelines in the Courts*, 19 THE JOINT COMM'N J. ON QUALITY IMPROVEMENT 313 (1993).

39. GAO REPORT *supra* note 5, at 3 ("Maine officials expect that the practice guidelines demonstration project will increase physicians' motivation to perform medically unnecessary diagnostic tests and treatment procedures . . .").

40. See generally Adam Wolff, *Practice Parameters in Health Reform: New State Approaches Precede Clinton Plan*, 21 THE J. OF L., MED. & ETHICS 394 (1994). Florida, Minnesota, Maryland, and Vermont have enacted health care reform legislation contemplating the use of practice guidelines. As of June 1993, guidelines had not yet been approved in Florida or Minnesota. Vermont's legislation allows state-sanctioned guidelines to be used as evidence of the standard of care. VT. STAT. ANN. tit. 12, § 7003 (1992). See also GAO REPORT, *supra* note 5, at 1. Vermont's statute does not allow providers to plead compliance with the guidelines as an affirmative defense to a malpractice claim.

41. See ME. REV. STAT. ANN. tit. 24, § 2972 (West Supp. 1993-1994).

42. The guidelines were prepared by committees formed by members of each particular specialty who used established national guidelines and incorporated changes the members felt appropriate for the specific practice and geographic areas. A primary concern was that physicians in smaller hospitals and rural areas not be required to follow the same procedures, and use the same technological equipment as, for example, Maine Medical Center, when they might not have such devices and equipment available. GAO REPORT, *supra* note 5.

tion, a group of emergency room physicians created their own protocols regarding: (1) cervical spine x-rays for acute trauma patients, (2) documentation of instructions to patients upon discharge, and (3) transferring patients pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 (C.O.B.R.A.).⁴³

The anesthesiology guidelines govern preanesthesia evaluation and documentation; standards for intraoperative monitoring including oxygenation, ventilation, circulatory function, and physiologic status; and criteria for preoperative testing.⁴⁴ The obstetrics guidelines contain ten detailed practice parameters regarding cesarean deliveries, hysterectomies, tocolysis, ectopic pregnancies, breech deliveries, perinatal herpes simplex virus infections, intrapartum fetal distress, and prolonged pregnancy.⁴⁵ The radiology guidelines govern screening mammography, antepartum ultrasound, outpatient angiography, and the performance of adult barium enema examinations.⁴⁶ Each of these three specialties include in their guidelines an "extenuating circumstance" exception for cases in which it would not be either medically necessary or appropriate to follow the particular parameters. The radiology guidelines, however, state, "[T]he ultimate judgment regarding the propriety of any specific procedure or course of conduct must be made by the radiologist in light of all circumstances presented by the individual situation."⁴⁷

Subsequent to the enactment of the guidelines legislation and the completion of the incorporated practice parameters, it became apparent that, unless the prelitigation screening panel provisions were amended to incorporate instructions on the treatment of the affirmative defense of compliance with the guidelines, the Demonstration Project would be rendered meaningless. Without integration into the prelitigation screening panel provisions, the defense of compliance could only be used at trial—well after the physician-defendant had completed the prelitigation screening panel process. To solve these problems the affirmative defense would have to be injected into the medical malpractice legislation and the scope of the panel's authority would have to be enlarged. Without such amendment, the panel had no jurisdiction to hear or decide any dispositive legal affirmative defenses except comparative negligence, absent the agreement of the parties. The necessary amendment, as enacted, specifically expanded the panel's jurisdiction to resolve dispositive legal affirmative defenses to include the issue of:

[C]ompliance with practice parameters or risk management protocols adopted under Section 2973 if the defendant is a

43. 7 Me. Code of Rules § 02 373 022 (1991).

44. 7 Me. Code of Rules § 02 373 020 (1991).

45. 7 Me. Code of Rules § 02 373 024 (1991).

46. 7 Me. Code of Rules § 02 373 026 (1991).

47. *Id.* at Introduction.

participant in the medical liability demonstration project established under subchapter IX and intends to introduce evidence of compliance at trial⁴⁸

The panel also was charged with determining, in addition to the issues of negligence and causation, "whether the defendant complied with an applicable parameter or protocol establishing the applicable standard of care."⁴⁹

III. IMPLICATIONS OF THE MAINE LEGISLATION

While a case testing the effectiveness of the guidelines legislation has yet to materialize,⁵⁰ the potential benefits, practical realities, and limitations of the statutory scheme should be acknowledged. Observers remain optimistic that the guidelines enactment will foreclose litigation against a physician or at least avoid significant steps in the defense process. In an explanation offered on national news coverage of the project, ABC News reporter Dr. Timothy Johnson described the legislation as a direct attack on the problem of defensive medicine and declared, "If doctors [follow] the guidelines . . . a malpractice lawsuit against them would be dismissed even if there is a birth complication."⁵¹ The news coverage representation also concluded that, "[Y]ou simply say, 'I met the standard.' And as long as you can show evidence that you did, you're out of the case."⁵²

This public perception and expectation is troubling in that it fails to take into account: (1) the legislation, which provides merely an affirmative defense, not immunity, does not shield physicians from Maine's prelitigation screening panel process and provides no guarantee with respect to avoiding trial; (2) inconsistencies in the legislative provisions may undermine certain goals of the enactment; and (3) the legislation may be vulnerable to constitutional challenges which, in addition to potentially invalidating certain legislative provisions in the project or in the prelitigation screening panel legislation, could complicate and prolong the judicial process involved in defending a medical malpractice claim.

48. ME. REV. STAT. ANN. tit. 24, § 2853(5) (West 1990 & Supp. 1993-1994).

49. ME. REV. STAT. ANN. tit. 24, § 2855 (A-1) (West 1990 & Supp. 1993-1994).

50. Although much has been made of Maine's pioneering efforts to test the physician-defendants' use of practice guidelines against malpractice charges, more than one and a half years into the project there is yet to be a case in which the guidelines can be applied. It is likely that the Project will remain untested, given the slight chance that during the five year Project period, which expires on January 1, 1997, any case will arise which would invoke the use of the guidelines.

51. *World News Tonight with Peter Jennings* (ABC television broadcast, Aug. 4, 1993) available in LEXIS, NEXIS Library, ABCNEW File.

52. *Id.* (quoting Gordon Smith, Maine Hospital Association counsel).

A. *Potential for Success of the Affirmative Defense*

Although the legislation may have certain shortcomings, there is a small window of cases within which the affirmative defense of "compliance" will offer a degree of protection to physician-defendants faced with defending themselves against an otherwise lengthy, complex medical malpractice action. This window, which would potentially shorten but not preclude a lawsuit, is only available if:

1. The physician-defendant was a participant in the Demonstration Project;
2. The action or inaction by the physician-defendant that constitutes the basis for the claim of malpractice *clearly* falls within, and is governed by, the legislatively incorporated practice guidelines;
3. The affirmative defense of compliance is asserted at the panel stage (or the panel is mutually waived) and is presented in a motion for summary judgment;
4. The panel chairperson agrees to submit the issue to the superior court for resolution by a superior court justice;
5. There are no material disputed facts and the plaintiff does not generate any disputed facts regarding sufficient compliance by the physician-defendant with the practice guidelines or lack of circumstances justifying non-compliance; and
6. The superior court grants summary judgment after review of all documents and affidavits and consideration of arguments in a non-testimonial hearing.

Unfortunately, for the reasons discussed below, it will be the extremely rare scenario in which all of the above factors are present, thus allowing the successful interjection of the affirmative defense of compliance.

B. *Inherent Obstacles Presented by the Prelitigation Screening Panel Provisions*

Analysis of a hypothetical medical malpractice action in the context of Maine's legal system illustrates why the mechanism of an affirmative defense is not likely to trigger the neatly outlined steps above and will not provide physicians the degree of protection sought by the legislation. As the hypothetical scenario will illustrate, the problem lies not so much with the theory underlying the legislation, or even with its drafting, as with the existence of the prelitigation screening panel requirements. The hypothetical scenario includes a claim of medical negligence asserted against an anesthesiologist who allegedly failed to ventilate and monitor appropriately a patient receiving general anesthesia.⁵³ In response to the plaintiff's

53. Appendix 1 of Chapter 20 of the Medical Liability Demonstration Project sets forth the anesthesiology practice parameters and provides, in pertinent part: "(a) every patient receiving general anesthesia shall have the adequacy of ventila-

claim, counsel for the physician-defendant raises as an affirmative defense the physician's compliance with the applicable practice guidelines. Because the allegation of negligence against the physician would be pursuant to a notice of claim invoking all of the requirements of the prelitigation screening panel, the assertion of the affirmative defense under physician guidelines would be subject to the procedural dictates of the screening panel provisions.

1. An Affirmative Defense at the Panel Stage

The fact that the prelitigation screening panel provisions are unavoidable significantly undermines the potential for the guidelines legislation to fulfill its mission of protecting physicians from, and decreasing generally, medical malpractice litigation. One major problem lies in the treatment of an affirmative defense in the context of the medical malpractice panel proceedings, given the nature of the affirmative defense. Technically, an affirmative defense is required to be pled in the answer to a complaint or it will be deemed waived.⁵⁴ Since the panel proceedings preclude the filing of a complaint in court, the defense cannot be pled in an answer.⁵⁵ The defining characteristic of an affirmative defense, and the reason it neither can terminate litigation at the panel stage nor fully protect physicians from having to defend a lawsuit, is that it constitutes a triable defense to an action while assuming the facts alleged in the complaint to be true unless specifically denied.⁵⁶ It does not provide immunity.⁵⁷

Once an affirmative defense has been asserted, the burden of proof shifts to the physician asserting it "in accordance with the gen-

tion continually evaluated (footnote omitted). While qualitative clinical signs such as chest excursion, observation of the reservoir breathing bag and auscultation of breath sounds may be adequate, quantitative monitoring of the CO₂ content and/or volume of expired gas is encouraged." 7 Me. Code of Rules § 02 373 020, at 8 (1991).

54. ME. R. CIV. P. 8(c); 12(b). See also *Bartlett v. Pullen*, 586 A.2d 1263, 1265 (Me. 1991); *Sargent v. Sargent*, 622 A.2d 721 (Me. 1993) (*res judicata* claimed regarding fraud allegation following divorce); RICHARD H. FIELD ET AL., MAINE CIVIL PRACTICE § 8.18 (Supp. 1981) (discussing affirmative defense of *res judicata*). The only exception to this is if the trial court finds the issue to have been tried by implied consent. See *Maine Mortgage Co. v. Tonge*, 448 A.2d 899, 901-02 (Me. 1982).

55. ME. REV. STAT. ANN. tit. 24, § 2859 (West Supp. 1993-1994).

56. See BLACK'S LAW DICTIONARY 55 (5th ed. 1979); 71 C.J.S. *Pleadings* § 158 (1951).

57. It has been suggested that the decision to inject the affirmative defense, rather than immunity, into the legislation was not viewed as problematic, or even as a real compromise. Instead, there was a belief that whether the mechanism was immunity or an affirmative defense, the same procedures would be necessary. In other words, it made no difference since the prelitigation screening panel procedures would still have to be followed, and the same standards would be applicable to either defense. Interview with Gordon Smith, *supra* note 32.

eral rule of evidence which places the burden of proving the affirmative of an issue upon the party alleging the facts constituting it and relying thereon."⁵⁸ The phrase "burden of proof" means both the burden of persuasion as well as the burden of producing evidence. This incorporates:

(1) [t]he peculiar duty of him who has the risk of any given proposition on which parties are at issue, who will lose the case if he does not make this proposition out, when all has been said and done . . . [and] (2) [i]t stands for the duty . . . of going forward in argument or in producing evidence; whether at the beginning of the case or at any later moment throughout the trial⁵⁹

Thus, the physician-defendant has the burden of proving compliance with the physician guidelines once the affirmative defense is asserted.

2. *The Affirmative Defense in Summary Judgment Proceedings*

The method by which a physician-defendant attempts to meet the applicable burden of proof will take the form of a motion for summary judgment.⁶⁰ In accordance with the Maine Rules of Civil Procedure, a physician asserting the affirmative defense of compliance will be deemed to have met the applicable burden of proof by submitting his or her own affidavit, based upon personal knowledge, that he or she complied with the applicable guidelines. Only in the most unusual circumstances would such a motion for summary judgment justify dismissal of the action against the physician. This is due to the reluctance of superior court judges to grant motions for sum-

58. 1 AM. JUR. 2D *Accord and Satisfaction* § 55; see generally *Windle v. Jordan*, 75 Me. 149 (1883) (defendant held to have burden of proof on defense that plaintiff was warned of vicious propensity of horse). See also *Cox v. Metropolitan Life Insurance Co.*, 139 Me. 167, 169-170 (Me. 1942) (defendant insurance company had burden to prove claim of suicide to avoid payment of policy).

59. JAMES B. THAYER, A PRELIMINARY TREATISE ON EVIDENCE AT THE COMMON LAW 355 (1896).

60. Typically, an affirmative defense may be pursued by a motion for judgment on the pleadings or a motion to dismiss pursuant to ME. R. Civ. P. 12(c), see, e.g., *Chiapetta v. Clark Assoc.*, 521 A.2d 697, 700 (Me. 1987), or via a motion for summary judgment pursuant to ME. R. Civ. P. 56. A Rule 12(b)(6) motion is appropriate to raise an affirmative defense only if the facts establishing the defense appear on the face of the complaint. See *Warren v. Waterville Urban Renewal Auth.*, 290 A.2d 362, 367-68 (Me. 1972) (denial of motion to dismiss based upon statute of limitations upheld because matters presented outside the pleadings transformed the motion into one for summary judgment, which was precluded by existence of disputed facts); *Patten v. Milam*, 468 A.2d 620, 621 (Me. 1983) (rule 12(b)(6) dismissal based upon grounds of *res judicata* upheld). Because any motion to dismiss based upon the issue of compliance with the physician practice guidelines will necessarily require an affidavit, the motion will be treated as one for summary judgment. See *Waterville Homes, Inc. v. Maine Dep't of Transp.*, 589 A.2d 455, 457 (Me. 1991).

mary judgment⁶¹ as well as to the peculiar nature of the affirmative defense of compliance. Moreover, denial of a motion for summary judgment based on the affirmative defense of compliance would be considered an interlocutory ruling, and not appealable, unless an exception to the final judgment rule were found to apply.⁶²

It is difficult to imagine a set of facts upon which compliance with the anesthesiology protocol would resolve all questions regarding compliance with the appropriate standard of care as a matter of law. One major obstacle is that the protocol itself raises questions with respect to the appropriate measures to be taken in the face of particular clinical signs. Specifically, a physician may claim to have complied with the practice guidelines by observing clinical signs such as chest excursion and auscultation of breath sounds in reaching a conclusion that the patient was adequately ventilated. Depending upon the circumstances of the case, however, additional steps such as quantitative monitoring of the CO₂ content or volume of expired gas might have been required.⁶³ In other instances, the "extenuating circumstances" exception could be invoked making the entire guideline inapplicable.⁶⁴ Thus, the language of the protocol is inherently, albeit necessarily, ambiguous.

The physician practice guidelines as applied in this hypothetical example do not, and cannot, paint a bright-line test for compliance with the medical standard of care. Further, it should be anticipated that merely raising the affirmative defense of compliance will not be dispositive of the legal issue of the standard of care. This is not to suggest that the particular guidelines under discussion are flawed. Instead, it is a recognition of the fact that decisions of medical care rest upon the nuances and facts of each particular case. Accordingly, a court faced with a motion for summary judgment based upon compliance with the guidelines will likely be constrained from ruling in the physician-defendant's favor. This is due, in addition to the ambiguities inherent in the language of the guidelines, to the challenges the plaintiff will raise to the motion.⁶⁵ Summary judg-

61. The Maine Supreme Judicial Court, sitting as the Law Court, has stated on several occasions that summary judgment motions are to be granted with caution, and should only be used in the rare, extreme circumstances when the lack of any disputed facts and a clear legal conclusion warrant entry of judgment as a matter of law. *See, e.g., Chadwick-BaRoss Inc. v. T. Buck Constr. Co.*, 627 A.2d 532, 534 (Me. 1993); *Utica Mutual Ins. Co. v. St. Paul Fire & Marine Ins. Co.*, 468 A.2d 315, 317 (Me. 1983); *Wallingford v. Butcher*, 413 A.2d 162, 165 (Me. 1980).

62. *See Dep't of Human Services v. Lowatchie*, 569 A.2d 197, 199-200 (Me. 1990) (allowing interlocutory appeal in paternity action based on judicial economy exception to final judgment rule).

63. *See supra* note 48.

64. *See supra* note 47 and accompanying text.

65. Opposition to a motion for summary judgment may be made by witness affidavits, answers to interrogatories, responses to requests for admissions, or even through certified medical records. *See ME. R. Civ. P. 56.*

ment is properly granted only if no genuine issue of material fact remains and the moving party is entitled to such judgment as a matter of law.⁶⁶ A plaintiff will undoubtedly seek to convince the court that disputed facts exist so as to preclude the entry of summary judgment.⁶⁷ The very nature of the affirmative defense of compliance may lead plaintiffs to (1) question whether the guidelines actually meet the appropriate national standard of care; (2) refute the physician's claim of compliance; or (3) indicate that the particular circumstances in the case did not justify following the particular guidelines raised in the affirmative defense but instead fell within an exception to the guidelines. For example, the plaintiffs in the anesthesiology hypothetical could claim that quantitative monitoring of the CO₂ content was necessary under the particular facts and circumstances of the case.

It is worth noting that the plain language of section 2855 and the inference that can be drawn therefrom suggests that the drafters of this provision envisioned resolution, not at the summary judgment stage, but after a full hearing before the panel. The provision expressly authorizes the panel to decide *after hearing* whether the defendant complied with an applicable parameter.⁶⁸ Thus, even summary judgment proceedings may present an unsuccessful avenue for resolution of the affirmative defense of compliance. The bottom line is that assertion of the affirmative defense does not necessarily avoid the physician-defendant having to proceed with the entire screening panel process. The most likely scenario is that the affirmative defense will not be ruled upon until the panel has fully and completely considered all of the evidence and testimony.

C. Inherent Shortcomings in the Practice Guidelines Statutory Scheme

As discussed above, there are certain theoretical obstacles presented by raising the affirmative defense of compliance in the context of a summary judgment motion at the prelitigation panel stage. The incorporation of the affirmative defense of compliance with physician practice guidelines into the prelitigation screening panel provisions also is problematic, for three logistical reasons. First, the affirmative defense and the practice guidelines could be used against the physician-defendant, notwithstanding the express instruction in the Demonstration Project that only the physician-defendant is permitted to raise the issue of compliance. The second problem lies in the non-exclusive nature of the panel's consideration

66. See *Saltonstall v. Cumming*, 538 A.2d 289, 290 (Me. 1988) (lower court grant of summary judgment vacated because Law Court found disputed facts existed regarding easement referenced in a deed).

67. See ME. R. CIV. P. 56(c).

68. ME. REV. STAT. ANN. tit. 24, § 2855(1)(A) (West 1990).

of the affirmative defense of compliance. Third, as a practical matter, the practice guidelines are not likely to obviate the need for expert testimony on the applicable standard of care.

1. *Exculpatory Use of the Evidence of Compliance
with Guidelines*

Much of the support garnered from the medical community for the Demonstration Project can be traced to the fact that the affirmative defense is intended to be used for exculpatory purposes only. The statute allows a plaintiff to use evidence regarding compliance with physician practice guidelines *only* "[i]f the physician or the physician's employer introduces *at trial* evidence of compliance with the parameters and protocols" ⁶⁹ The screening panel provisions which govern the claim against the physician, however, undermine this aim of section 2975. The provisions may allow plaintiffs to avoid the legislature's desire that they use evidence regarding physician guidelines only in narrow circumstances.

If the hypothetical anesthesiologist referenced earlier asserts compliance with an applicable guideline, but the panel unanimously finds in favor of the plaintiff, such a finding would be admissible against the physician in a subsequent trial. ⁷⁰ The panel could find in favor of the plaintiff by concluding that the physician-defendant did not comply with the guidelines, *or* that the circumstances of the case justified deviation from the protocol, *or* that the physician-defendant was otherwise negligent. Yet, no matter how the panel arrives at its conclusion, the prelitigation screening panel provisions require all unanimous findings to be revealed to a jury. ⁷¹ Thus, notwithstanding the intent of the guidelines legislation that the affirmative defense be available for exculpatory purposes only, there is risk to the physician-defendant that the defense could be used against him at trial.

69. ME. REV. STAT. ANN. tit. 24, § 2975(2) (West Supp. 1993-1994) (emphasis added). Although the prelitigation screening panel legislation was amended to allow consideration of the defense by the panel, the Demonstration Project provision (section 2975) has not been amended to reflect that change and only indicates that the plaintiff may present rebuttal evidence *at trial*. Presumably, that is not the legislature's intent. If the defendant raises the defense of compliance *at the panel stage* (and not just at trial) the plaintiff would be permitted to present evidence on the issue before the panel.

70. ME. REV. STAT. ANN. tit. 24, § 2857(1)(A) (West 1990).

71. See *Sullivan v. Johnson*, 628 A.2d 653, 656 (Me. 1993) (holding that the statute states that the unanimous conclusions shall be admissible "without explanation"; the jury may be advised as to the results of the panel proceedings; and that the panel process is a preliminary procedural step through which malpractice claims proceed).

2. *The Non-Exclusive Findings Regarding Compliance with Guidelines*

Another aspect of the prelitigation screening panel legislation with critical implications for a physician-defendant asserting the affirmative defense of "compliance" is that the panel's consideration of the defense is not exclusive and a plaintiff is not precluded from pursuing the negligence and causation prongs of the malpractice claim. In other words, the hypothetical anesthesiologist who raises the affirmative defense of compliance is not automatically dismissed from the suit.

The prelitigation screening panel legislation requires the panel to determine first whether the physician complied with applicable guidelines, second whether the physician was negligent, and third, if the physician was negligent, whether the negligence was a proximate cause of the plaintiff's injuries.⁷² It appears that compliance with the guidelines does not preclude the determination of the negligence and compliance issues.⁷³ Thus, a unanimous ruling in the physician's favor after the panel hearing on the compliance issue does not necessarily preclude the panel's ruling against the physician on the negligence and causation issues.

This seemingly inconsistent result may be explained in the context of a plaintiff's challenge to the appropriateness of adhering to a particular practice parameter. The prelitigation panel could find that although the physician complied with the applicable guideline, an exception existed which justified deviation from the standard. If the legislation were drafted so that a finding of compliance precluded any further inquiry, it would be inconsistent with the nature of an affirmative defense, in that the plaintiff would be unable to contest the compliance defense. In effect, a finding in a physician-defendant's favor on the compliance prong, if conclusive at the panel stage, would be tantamount to immunity: the physician would not be exposed under the legislation's negligence and causation prongs.

72. ME. REV. STAT. ANN. tit. 24, § 2855 (West 1990 & Supp. 1993-1994).

73. Subsection (A-1), the compliance prong of section 2855, is not followed by the word "or." This allows the inference that even if the defense of compliance is raised, the panel must still determine separately the negligence and causation issues. Specifically, the statute reads:

If the defendant is a participant in the medical liability demonstration project established under subchapter IX and has raised as an affirmative defense compliance with the practice parameters or risk management protocols adopted under section 2973, whether the defendant complied with an applicable parameter or protocol establishing the applicable standard of care;

ME. REV. STAT. ANN. tit. 24, § 2855(1)(A-1) (West Supp. 1993-1994).

3. Use of Experts

Although it has been suggested that physician practice guidelines could be used as evidence to establish an applicable standard of care without the need for accompanying medical expert testimony,⁷⁴ several obstacles may impede this laudable goal. For instance, defense experts may be necessary to explain the guidelines and justify their admissibility as conclusive evidence of a standard of care.⁷⁵

An additional need for expert testimony arises in the context of a plaintiff's claim that a certain guideline is not the appropriate standard of care under the particular facts and circumstances of the case. Such a claim would incorporate challenges to the up-to-date nature of the guideline, whether a different guideline (by a separate medical entity or organization) were preferable, or whether the facts of the case justified application of one of the exceptions to the guidelines.

The informal nature of the panel stage may make the above scenarios irrelevant at a panel hearing, but they would certainly be critical at trial. Moreover, even prior to a hearing, full discovery, including interrogatories and depositions of both the parties as well as of experts, could be allowed on these issues and further impede the goal of expediting medical malpractice litigation.⁷⁶

IV. POTENTIAL CONSTITUTIONAL CHALLENGES TO THE LEGISLATION

Except for those few cases that may be appropriate for dismissal based upon compliance with practice guidelines, physician-defendants should be prepared to confront at least two constitutional challenges to the guidelines legislation, either of which could result in invalidation of the legislation. First, should the statutory provisions be deemed to authorize the panel, rather than a judge or jury, to decide the dispositive legal issue of compliance with physician guidelines, both Maine and federal constitutional concerns could be implicated. Second, should a plaintiff seek to utilize evidence regarding compliance with practice guidelines offensively, and be

74. See, e.g., GAO REPORT, *supra* note 5, at 20. *Contra*, Brennan, *supra* note 20 (offering opinion that guidelines would be supplemented by expert testimony).

75. GAO REPORT, *supra* note 5, at 20. A related need for experts arises in the context of the admissibility of the written parameters in the face of hearsay objections. The hearsay rule, which bars out of court statements offered to prove the truth of the matter asserted, is only overcome by one of a number of exceptions. The one recognized exception which might apply and which would obviate the need for expert testimony is a "learned treatise" exception. This exception, however, allows introduction of a statement (here, a practice guideline) only in conjunction with the testimony of an expert witness. If admitted, "the statements may be read into evidence but may not be received as exhibits." FED. R. EVID. 803(18).

76. ME. REV. STAT. ANN. tit. 24, §§ 2853(4), 2857(3) (West 1990 & Supp. 1993-1994).

barred from doing so by the provision which allows only defendant physicians to enter such evidence, a constitutional challenge would likely be upheld. Any constitutional inquiry would entail an analysis of whether the panel procedures: (1) constituted an improper usurpation of a judicial function; (2) deprived plaintiffs of the right to a jury trial; or (3) constituted a violation of the Equal Protection and Due Process Clauses of the Federal and Maine Constitutions.

A. Resolution of the Affirmative Defense by the Panel

Notwithstanding the express provision of the screening panel legislation which empowers the panel to "resolve the dispositive legal affirmative defense" of compliance with practice parameters,⁷⁷ the referenced "resolution" should be interpreted to bestow upon the panel the authority only to consider the defense of compliance at hearing and to enter findings on each of the prongs of the statute, including compliance. If a final judgment were entered in a case based on a panel determination on the issue of compliance with practice guidelines, the legislation could be deemed unconstitutional as an improper usurpation of the judicial process, in that it deprives a physician-defendant of his or her right to a trial by jury.

A fair reading of the language of the Demonstration Project legislation,⁷⁸ in conjunction with the amended prelitigation screening panel provisions,⁷⁹ supports the interpretation that *only* the superior court, and *not* the panel, may decide as a matter of law the dispositive affirmative defense of compliance with physician practice guidelines. The legislation, however, allows the panel to "hear and decide" the affirmative defense of compliance. There is no reason to believe that this affirmative defense should be treated any differently from the affirmative defense of comparative negligence, which is the one other instance where the panel lacks the authority to resolve dispositive legal affirmative defenses. For either defense, the panel is required to enter findings after full hearing rather than at the summary judgment stage.⁸⁰ These findings themselves do not operate as complete adjudication of the claim, but merely indicate to the parties what a jury might do at trial. A unanimous finding, which would be admissible at trial, might compel the parties to reach a settlement. In any event, the panel's findings on compliance do not resolve the action but rather constitute one step in a process that may culminate in a trial.

The plain language of the prelitigation screening panel statute supports the assertion that the panel's authority to decide the affirmative defense of compliance is limited to entering findings at the

77. ME. REV. STAT. ANN. tit. 24, § 2853(5) (West Supp. 1993-1994).

78. ME. REV. STAT. ANN. tit. 24, §§ 2971-2979 (West Supp. 1993-1994).

79. ME. REV. STAT. ANN. tit. 24, §§ 2851-2859 (West 1990 & Supp. 1993-1994).

80. ME. REV. STAT. ANN. tit. 24, § 2855(1) (West 1990 & Supp. 1993-1994).

panel stage and does not result in a dismissal of the suit. Specifically, section 2853 of Title 24 confers on the panel the jurisdiction to hear or decide the affirmative defense *only if* the defendant "intends to introduce evidence of compliance at trial."⁸¹ There is no procedure in the statute by which a defendant notifies the panel of such an intention. Presumably, a defendant raising the affirmative defense at the panel stage intends to follow the same strategy at trial. The legislation does not discuss the treatment of a defendant who reserves the right to alter strategies and discard the affirmative defense of compliance for the trial process. Nor does the statute address whether defendants who seek to avoid trial altogether by filing a motion for summary judgment at the panel stage are deemed to "intend to introduce evidence at trial" if the motion for summary judgment is denied. In any event, the panel is *not* authorized to address the affirmative defense of compliance for physicians who indicate that the defense will not be raised at trial.

Assuming, *arguendo*, that a physician-defendant convinced the panel or the court to dismiss a case using a motion for summary judgment, based upon a unanimous finding by the panel that the physician complied with approved practice guidelines, the decision would be constitutionally suspect. While the goals of the Demonstration Project to curtail the length, complexities, and costs of malpractice litigation would be served by such a decision, it would likely fall short of certain constitutional requirements. The most likely challenges would be based upon either Article III of Maine's Constitution or upon the State and Federal Constitutional guarantees regarding jury trials.

1. *Usurpation of a Judicial Function*

Whether the panel chairperson has the authority and jurisdiction to make a final, binding determination with respect to the affirmative defense of compliance is governed by Article III of the Maine Constitution, which expressly provides that, "No person or persons, belonging to one of these departments, shall exercise any of the powers properly belonging to either of the others, except in the cases herein expressly directed or permitted."⁸² The Maine Constitution also provides, "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."⁸³

If a panel chairperson construes the screening panel legislation to bestow upon the panel the authority to decide the issue of compli-

81. ME. REV. STAT. ANN. tit. 24, § 2853(5) (West Supp. 1993-1994).

82. ME. CONST. art. III, § 2.

83. ME. CONST. art. I, § 4.

ance with physician practice guidelines as a matter of law, the legislation could be deemed unconstitutional as applied, as it permits usurpation of a judicial function. If, on the other hand, the panel restricts its role to deciding the three prongs of the malpractice criteria (compliance, negligence, and causation), and the case is transferred to the superior court for the litigation stage, as contemplated by the statute, no constitutional infirmities are implicated. The superior court cannot dismiss a case solely because there was a unanimous panel finding of compliance with applicable guidelines. If the court could dismiss a case for that reason, the panel findings would be accorded a weight that the legislation neither intended nor instructed. Instead, the court should either address a summary judgment motion filed by either party or schedule the case for discovery and trial. Adherence to these procedures is contemplated by the legislation and affords litigants their rights with respect to the judicial process.

2. *Right to Trial by Jury*

The first substantive clause of the Seventh Amendment to the United States Constitution provides, "In suits at common law . . . the right of trial by jury shall be preserved"⁸⁴ and thus guarantees the right to a jury trial in civil actions brought in federal courts. Although the Seventh Amendment does not apply to the states, the Maine Constitution provides, "In all civil suits . . . the parties shall have a right to a trial by jury, except in cases where it has heretofore been otherwise practiced"⁸⁵

Maine's constitutional provision has been construed to safeguard a litigant's right to a jury trial on all legal claims⁸⁶ except "in cases where it has heretofore been otherwise practiced."⁸⁷ The exception applies to equity cases or when it is affirmatively shown that a jury trial would not have been available for the particular type of action in 1820,⁸⁸ the year Maine's Constitution was adopted. Because the right to a jury trial did exist prior to 1820 for civil actions related to medical malpractice, a litigant's right in this area is preserved pursuant to Maine's Article I, section 20. Only if there are no "questions

84. U.S. CONST. amend. XII.

85. ME. CONST. art. I, § 20.

86. *City of Rockland v. Rockland Water Co.*, 86 Me. 55, 29 A. 935 (1893) (if equitable powers of the court were enlarged, other than by statute, the right of trial by jury—available only at law and not in equity—might be improperly narrowed or denied).

87. ME. CONST. art. I, § 20.

88. See *Harriman v. Maddocks*, 560 A.2d 11, 12 (Me. 1989); see also, *Cyr v. Cote*, 396 A.2d 1013, 1016 (Me. 1979) (dispute regarding terms of will).

of fact that the substantive law makes material" may the case be decided by the court prior to submission to a jury.⁸⁹

The guidelines legislation should not be construed to allow disposition of a case without full and proper consideration by either the superior court on summary judgment⁹⁰ or by a jury at trial. Any other construction that results in the dismissal of a suit, when the dismissal is based solely upon a finding of compliance with a practice guideline, would be an unconstitutional violation of the right to trial by jury. While numerous courts have addressed and rejected Seventh Amendment challenges to medical malpractice legislation imposing caps on damages awards,⁹¹ no court has been confronted with a deprivation of jury trial claim in the circumstances potentially presented by the Maine legislation.

In *Boucher v. Sayeed*,⁹² the Rhode Island Supreme Court declared, construing its state constitution in the context of a challenge to its own medical malpractice prelitigation screening panel enactment,⁹³ that: "[T]rial by jury is inviolate The right is thus placed absolutely beyond the power of the legislature to alter or abolish it."⁹⁴ Although the *Boucher* court did not reach the issue of whether the Rhode Island revised medical malpractice screening panel legislation violated the right to a jury trial,⁹⁵ the court noted the unlikelihood of the statute's passing constitutional muster since "[T]he law, as written, provides no recourse for a plaintiff whose claim is denied by the hearing justice, thereby infringing upon his right to a jury trial."⁹⁶

Arguably, the Maine legislation also provides no recourse for a plaintiff if a medical malpractice claim can be dismissed with prejudice upon the mere finding that the physician-defendant complied

89. *Peters v. Saft*, 597 A.2d 50, 53 (Me. 1991) (quoting *English v. New England Medical Center*, 541 N.E.2d 329, 331 (Mass. 1989)).

90. Full consideration is intended to mean that the superior court could not grant summary judgment based on the mere assertion by a defendant physician of compliance with a practice guideline. ME. R. CRV. P. 56.

91. James F. Tiu, *Challenging Medical Malpractice Damage Award Caps on Seventh Amendment Grounds: Attacks in Search of a Rationale*, 59 U. CIN. L. REV. 213 (1990).

92. *Boucher v. Sayeed*, 459 A.2d 87 (R.I. 1983).

93. The statute, as amended, replaced the medical malpractice screening panel proceedings with a single trial justice charged with determining whether the "evidence presented by the plaintiff, if properly substantiated and viewed in a light most favorable to the plaintiff, would be sufficient to raise a legitimate question of liability appropriate for judicial inquiry, or whether the plaintiff's case is merely an unfortunate medical result." R.I. GEN. LAWS § 10-19-4 (1981) (repealed 1985). If the trial justice concluded the latter, the action would be dismissed with prejudice. *Id.*

94. *Boucher v. Sayeed*, 459 A.2d at 91 n.13 (quoting *Dyer v. Keefe*, 198 A.2d 159, 160 (R.I. 1964)).

95. The Rhode Island statute was held unconstitutional on other grounds, and thus it was not necessary for the court to reach the jury-trial issue.

96. *Boucher v. Sayeed*, 459 A.2d at 91 n.13.

with the practice guidelines. A medical malpractice litigant's right to a jury trial includes a full hearing before a factfinder. The statute contemplates that the panel will restrict its role to deciding the three prongs of the malpractice criteria; it should not be construed to allow the panel to replace the jury function. Absent a circumstance in which a case clearly falls within the narrow window discussed earlier (in which a practice guideline is clearly invoked, a physician-defendant alleges compliance with the guideline, and no facts exist to create a dispute regarding that compliance), the matter should be resolved only after panel hearing and full trial before a jury. If the statute is so construed, it should survive a challenge that it violates the constitutional guarantee to a trial by jury.

B. Use of Evidence by Defendants Only

The Demonstration Project was implemented with the specific purpose and intent of making evidence regarding compliance with physician practice guidelines available only to physician-defendants. Plaintiffs' use of this evidence is limited to those circumstances in which "the physician or the physician's employer introduces at trial evidence of compliance with the parameters and protocols" ⁹⁷ This aspect of the legislation, that evidence is limited to use by defendants, presents the most constitutionally suspect provision of the Demonstration Project. If this legislation is invoked, and a panel or court prohibits a plaintiff from offering evidence or pursuing testimony regarding a physician-defendant's compliance (or lack thereof) with a guideline, the legislation will likely be challenged as a violation of the Equal Protection and Due Process Clauses of both the Federal and State Constitutions.

One Maine legislator has stated the issue simply:

Do you think that one party in an action, be it a trial or be it a prelitigation screening panel, do you think that one party ought to be able to introduce evidence that is useful to the fact finder but the other party should not be able to introduce the evidence? ⁹⁸

Although stated as a matter of fairness, the validity of the provision would depend, if presented to a court, on whether the disparate treatment of the parties amounted to a violation of the State or Federal Constitutions.

1. Challenges to the Legislation on Equal Protection Grounds

The Maine Constitution guarantees that, "[N]o person shall be . . . denied the equal protection of the laws" ⁹⁹ The critical inquiry

97. ME. REV. STAT. ANN. tit. 24, § 2975(2) (West Supp. 1993-1994).

98. Legis. Rec. 1074 (1991) (statement of Rep. Stevens).

99. ME. CONST. art. I, § 6-A.

in the face of a claim that legislation violates this guarantee is whether, depending upon the nature of the right at stake, the "varying treatment of different groups or persons is so unrelated to the achievement of any combination of legitimate purposes that [a court] can only conclude that the legislature's actions were irrational."¹⁰⁰ Both the nature of the classification and the individual rights at stake determine the appropriate test to be applied.

A strict scrutiny standard is used when a statute's different treatment of a select class of persons either infringes upon fundamental rights¹⁰¹ or results in the creation of a suspect classification.¹⁰² In such circumstances the classification must be narrowly tailored to promote a compelling state interest.¹⁰³ If the classification is not suspect and does not involve categories of persons based upon race, alienage, or illegitimacy, for example, and does not impinge upon a fundamental right such as religion, speech, voting, or procreation, the appropriate standard to be applied to the legislation is the rational basis test.¹⁰⁴ A statutory classification reviewed under the rational basis test will be invalidated only if the classification is clearly arbitrary. According to the United States Supreme Court, the test of a statute's arbitrariness is whether it rests "upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike."¹⁰⁵ The Maine Supreme Judicial Court, sitting as the Law Court, articulated the rational relationship standard as focusing on whether the challenged legislation has a legitimate purpose and whether it was reasonable for the legislature to believe that use of the challenged classification would promote that purpose.¹⁰⁶ The

100. *Houk v. Furman*, 613 F. Supp. 1022, 1030 (D. Me. 1985) (quoting *Hodel v. Indiana*, 452 U.S. 314, 332 (1981)).

101. See, e.g., *Zablocki v. Redhail*, 434 U.S. 374 (1978) (right to marry).

102. See, e.g., *Graham v. Richardson*, 403 U.S. 365 (1971) (alienage); *Loving v. Virginia*, 388 U.S. 1 (1967) (race).

103. See, e.g., *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 440 (1985) (finding that mental retardation is not a "quasi-suspect" classification, but holding invalid under the rational basis test an ordinance requiring license for group home); *Butler v. Supreme Judicial Court*, 611 A.2d 987, 992 n.9 (Me. 1992) (holding Maine jury-trial fee constitutional).

104. See generally *Gregory v. Ashcroft*, 501 U.S. 452, 470 (1991) (quoting *Vance v. Bradley*, 440 U.S. 93, 97 (1979)) (upholding on rational basis standard an age-based classification for mandatory judicial retirement).

105. *Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920) (striking down, under the rational basis test, a discriminatory corporate taxation statute); see also *Reed v. Reed*, 404 U.S. 71 (1971) (discrimination by gender in applications for administrators of probate estates held unconstitutional under rational relationship test).

106. *Foucher v. City of Auburn*, 465 A.2d 1120, 1125 (Me. 1983).

court has found differential treatment justifiable "if the facts may be reasonably conceived to justify the distinction."¹⁰⁷

A number of courts considering constitutional challenges to state legislation regarding medical malpractice litigation have held the enactments to a "heightened scrutiny" standard which requires more rigorous scrutiny than under the traditional rational basis test.¹⁰⁸ The rationale underlying the application of this heightened standard is that the class of affected persons, medical malpractice claimants, is determined to be "quasi-suspect."¹⁰⁹ In finding medical malpractice claimants to fall within a quasi-suspect class, the Kansas Supreme Court concluded that malpractice victims were similar to groups such as women, illegitimates, minorities, and illegal aliens, all of whom have been afforded "quasi-suspect" status.¹¹⁰ The similar qualities cited by the court for medical malpractice claimants included lack of cohesiveness and lack of political organization, both of which the court found justified additional protections.¹¹¹

As a general matter, the nature of the classification in the Maine legislation involving physician practice guidelines is between plaintiffs in medical malpractice cases as opposed to plaintiffs in any other tort litigation. The rights at stake include the entitlement to use evidence that would be available to litigants in other civil contexts to assist plaintiffs in proving a claim. The right to a fair and impartial trial is implicated if the nature of the process is altered by the litigant's inability to present relevant, probative evidence.

A survey of the jurisdictions in which equal protection challenges to tort reform measures in the medical malpractice arena have been addressed suggests that the classification in the Maine legislation would be tested according to the rational basis standard. First, it appears to be the majority view that equal protection challenges to medical malpractice legislation should be viewed as neither infringing upon a fundamental right nor involving a suspect classification.¹¹² The distinction between medical malpractice plaintiffs and

107. *Dishon v. Maine State Retirement Sys.*, 569 A.2d 1216, 1217 (Me. 1990) (quoting *McNicholas v. York Beach Village Corp.*, 394 A.2d 264, 269 (Me. 1978)).

108. See generally *Carson v. Maurer*, 424 A.2d 825, 830 (N.H. 1980); *Arneson v. Olson*, 270 N.W.2d 125, 133 (N.D. 1978). Compare *Murphy v. Edmonds*, 601 A.2d 102 (Md. 1992) (finding that legislation imposing a "cap" on economic damages recoverable by a medical malpractice plaintiff is properly analyzed under the rational basis test as economic regulation).

109. For example, gender-based classifications have been subjected to heightened scrutiny. *Craig v. Boren*, 429 U.S. 190, 197 (1976).

110. *Farley v. Engelken*, 740 P.2d 1058, 1064 (Kan. 1987).

111. *Id.* (quoting Howard A. Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional 'Quid Pro Quo' Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS., 143, 184, 189 (1981)).

112. See, e.g., *Boucher v. Sayeed*, 459 A.2d 87 (R.I. 1983); *Doran v. Priddy*, 534 F. Supp. 30 (D. Kan. 1981); *Carson v. Maurer*, 424 A.2d 825 (N.H. 1980); *Beatty v. Akron City Hosp.*, 424 N.E.2d 586 (Ohio 1981).

litigants in other civil matters has simply not raised fundamental constitutional concerns. Second, notwithstanding that other state courts have applied a heightened scrutiny analysis to medical malpractice legislation, the Federal District Court in Maine in *Houk v. Furman*¹¹³ determined that the appropriate test to be applied in the context of an equal protection challenge to the prelitigation notice requirements contained in Maine's medical malpractice legislation is the "rational relationship test."¹¹⁴

In *Houk* the court relied largely upon Maine's explicit refusal to extend equal protection and due process rights beyond the federal constitutional norm¹¹⁵ and was not convinced that the malpractice litigants fell within any special circumstances warranting a departure from the rational relationship test.¹¹⁶ Instead, the court treated the legislation as social or economic regulation.¹¹⁷ In order for any Maine court to apply a heightened scrutiny analysis to the guidelines legislation, the court would have to find a distinction between the affected class in these circumstances and the class affected by the prelitigation notice requirements. In fact, the class is exactly the same—victims of alleged medical malpractice. The difference is only in the implications of the legislation and the effects on the litigants' procedural rights. Accordingly, the court would likely follow the *Houk* rationale and apply the rational basis test.

Even assuming a Maine court would apply the lowest level of scrutiny, the rational basis test, to the guidelines legislation, the fact that it denies plaintiffs use of relevant evidence regarding compliance with guidelines would likely render at least that aspect of the legislation unconstitutional. The court's inquiry would necessarily focus upon the legislative intent in imposing evidentiary restrictions upon medical malpractice plaintiffs. Undoubtedly, one of the major purposes behind the legislation is "to resolve malpractice claims by eliminating the need to litigate to establish the standard of care."¹¹⁸ If this is the goal, using guidelines to establish the standard of care should be equally applicable to both the plaintiff and the defense.

The legislative record reflects additional purposes of the guidelines provisions, one of which is helping "to avoid future malpractice claims and to decrease the cost of defensive medicine . . . [and to] reduce the costly battle with experts that often occurs in malpractice cases."¹¹⁹ Again, if the use of guidelines in legislation is intended to achieve these goals, it is unclear why they are not furthered by equal application to plaintiffs and defendants. It is difficult to define how,

113. 613 F. Supp. 1022 (D. Me. 1985).

114. *Id.* at 1030.

115. *Id.* at 1029.

116. *Id.* at 1028.

117. *Id.*

118. GAO REPORT, *supra* note 5, at 3.A.

119. Legis. Rec. H756 (1990).

if at all, this provision constitutes a "fair and substantial relation to the object of the legislation" under the Supreme Court's arbitrariness test. Even the Maine articulation—whether "[the] facts may be reasonably conceived to justify the distinction"¹²⁰ between medical malpractice and other tort litigants—would be difficult to meet. It seems more likely that the provision denying plaintiffs access to evidence would complicate, rather than reduce, litigation by generating appealable issues.

A comparison of medical malpractice to other categories of litigation further highlights the questionable justification for the distinction. No other area of law comes to mind in which plaintiffs would be prohibited from using relevant evidence regarding standards, guidelines, or usual and customary practices in similar circumstances.

Numerous examples, including whether a landlord is aware of national safety standards regarding handrails for stairs, whether a manufacturer is knowledgeable regarding the suggested use of safety devices such as guards for a particular product, and whether a truck driver is aware of industry standards regarding allowable load limits for his vehicle, illustrate that, regardless of the incorporation of the standards followed by a profession or industry into legislation, the evidence of those standards is probative of whether the defendant acted appropriately under all of the circumstances. The factfinder is entitled to conclude that the standards are not applicable given the particular nuances of the case or that the defendant need not have followed the standards in light of the circumstances at the time of the occurrence. Only medical malpractice plaintiffs, however, seem to be denied complete use of such evidence. Denying plaintiffs in medical malpractice litigation this procedural benefit cannot be supported by a rational basis.

Putting aside momentarily the questionable causal connection between the primary goals of the physician practice guidelines enactment and the provision which denies plaintiffs the use of evidence regarding compliance with guidelines, the viability of the provision may be threatened by the lack of an explanation in the Statement of Fact as to the rationale or justification for such a provision. The intent behind the enactment is found only in the limited legislative record and not in the enactment itself. This could prove fatal, even under a rational relationship analysis. The *Boucher* court declined to speculate about unexpressed state interests behind the amendments to Rhode Island's medical malpractice legislation. The court pointed out, "Statutes aimed at providing relief in a time of crisis depend for their validity upon a proper exercise of the police power and ordinarily contain a declaration of legislative findings of fact

120. *Dishon v. Maine State Retirement System*, 569 A.2d 1216, 1217 (Me. 1990) (quoting *McNicholas v. York Beach Village Corp.*, 394 A.2d 264, 269 (Me. 1978)).

involving the public health, safety, or morals."¹²¹ The Statement of Fact¹²² for Maine's guidelines legislation merely reflects that the practice parameters will be developed by particular specialty committees and that the protocols may be used by a physician as an affirmative defense in a claim for professional negligence.¹²³ If a Maine court addressing the lack of a preamble to explain the legislative intent behind the enactment follows the lead of the Rhode Island court, the legislation could be struck down as a violation of the equal protection clause.

The most likely rationale for allowing only physician-defendants to use evidence regarding compliance with physician practice guidelines is that it serves as an enticement to physicians to participate in the Demonstration Project and in a sense affords physicians the immunity otherwise not attained by the legislation. If the physician is a participant in the Demonstration Project and he or she followed an applicable guideline, evidence of such compliance may be used to his or her benefit.¹²⁴ Participation without compliance, according to the legislation, could not be used to "incriminate" the physician. Such enticement would not, and should not, be deemed by any court to justify the disparate treatment of medical malpractice litigants under this provision of the legislation.

2. *Challenges to the Legislation on Due Process Grounds*

A decision that denied a plaintiff use of evidence regarding compliance with physician practice guidelines would likely face a successful challenge on due process grounds. The Maine Constitution provides, "No person shall be deprived of life, liberty, or property without due process of law"¹²⁵ and also states, "Every person,

121. *Boucher v. Sayeed*, 459 A.2d 87, 93 (R.I. 1983) (quoting Opinion to the Governor, 63 A.2d 724, 729 (R.I. 1949)).

122. The preamble to the separate acts adopting the specific guidelines for the four specialties contain cursory statements reflecting the legislative concerns. For example, the preamble to ME. REV. STAT. ANN. tit. 24, § 2972 (West Supp. 1993-1994) regarding the radiological guidelines concludes that, "[I]n the judgment of the legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety" No explanation is provided, however, with respect to how enactment of the adoption of the particular guidelines preserves the public peace, health, or safety.

123. L.D. 2513, Statement of Fact (114th Legislature 1990).

124. If the physician does *not* participate in the project, *and* does not comply with a legislatively incorporated or any other written, applicable guideline, evidence of such failure to comply would fall outside the protective shield of the statute and the evidence would be admissible. It is also worth noting that it is only the specific guidelines that are incorporated into the legislation that are restricted to use by defendants. Any applicable guidelines, standards, or parameters otherwise relevant to the physician-defendant's conduct that are not part of the Demonstration Project presumably would be fair game for use by a plaintiff against the physician.

125. ME. CONST. art. I, § 6-A.

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."¹²⁶ The Maine Constitution and the United States Constitution are declarative of identical concepts of due process.¹²⁷ The Law Court has repeatedly recognized that due process is a flexible concept, entailing no particular form or procedure.¹²⁸ Factors to be considered in a due process analysis include the importance of the individual's interest, the potential for governmental error, and the magnitude of the State's interest.¹²⁹ Any challenge on due process grounds, however, to the constitutionality of the physician practice guidelines faces the presumption of the statute's constitutionality.¹³⁰

Generally, a legislative enactment challenged on due process grounds will be upheld if: (1) the goal of the legislation is to provide for the benefit of the public welfare, (2) the means employed are appropriate to the achievement of the ends sought, and (3) the manner of carrying out the legislative provision is not unduly arbitrary or capricious.¹³¹

It is well established that legislative acts adjusting economic burdens and benefits carry a presumption of constitutionality and that the party challenging an enactment on due process grounds must establish that the legislature has acted in an arbitrary and irrational manner.¹³² In *Houk v. Furman*¹³³ the federal district court rejected a due process challenge to Maine's prelitigation screening panel notice requirements. The court found that the legislation "is rationally related to the legitimate objective of assuring the continued availability of affordable health care in the face of increasing insurance costs attributable, in part, to litigation costs."¹³⁴ Indeed, the majority of jurisdictions confronting due process challenges to medical malpractice legislation have rejected the challenges and upheld the enactments as constitutional.¹³⁵

126. ME. CONST. art. I, § 19.

127. *Penobscot Area Hous. Dev. Corp. v. City of Brewer*, 434 A.2d 14, 24 n.9 (Me. 1981).

128. See, e.g., *Fichter v. Board of Env'tl. Protection*, 604 A.2d 433, 436-37 (Me. 1992); *Giberson v. Quinn*, 445 A.2d 1007, 1008 (Me. 1982).

129. *Mahaney v. State*, 610 A.2d 738, 742 (Me. 1992).

130. See *Chestnut v. Magnusson*, 942 F.2d 820, 823-24 (1st Cir. 1991).

131. See *State v. Rush*, 324 A.2d 748, 753 (Me. 1974).

132. See *Houk v. Furman*, 613 F. Supp. 1022, 1033-34 (D. Me. 1985) (quoting *Usery v. Turner Elkhorn Mining Company*, 428 U.S. 1, 15 (1976)).

133. *Id.*

134. *Id.* at 1034.

135. See generally *Tiu*, *supra* note 91; see also Larry S. Milner, *The Constitutionality of Medical Malpractice Legislative Reform: A National Survey*, 18 *LOV. U. CHI. L.J.* 1053 (1987).

Other jurisdictions, however, have sustained due process challenges. For example, in *Morris v. Savoy*¹³⁶ the Ohio Supreme Court found that a cap on the amount of damages that could be recovered by a plaintiff in a medical malpractice case failed to pass constitutional muster. The court reasoned, "It is irrational and arbitrary to impose the cost of the intended benefit to the general public solely upon a class consisting of those most severely injured by medical malpractice."¹³⁷ Similarly, in *Arneson v. Olson*¹³⁸ the North Dakota Supreme Court found that the cumulative effect of several provisions in that state's medical malpractice legislation violated the right of medical patients to due process of law.¹³⁹ By comparison, the Maine statute does not contain the array of suspect provisions addressed by the *Arneson* court, nor is it marked by the kind of bold limitation on recovery found unconstitutional by the Ohio court in *Savoy*. However, denying one party access to relevant information, while allowing another party the use of the same information, as does section 2975 of the Maine statute does, may trigger similar constitutional concerns.

As discussed above, the inconsistencies in the legislative provisions regarding the limited exculpatory use of the guidelines could render meaningless the restriction contained in section 2975 of the Demonstration Project legislation. This would occur if there were a unanimous finding against a physician at the panel stage. Assuming such a case arises, in which a court prohibits a plaintiff from presenting evidence to a jury of a physician's lack of compliance with physician guidelines, a reviewing court presumably would have some difficulty in finding a rational basis to support this procedural distinction while still concluding that the plaintiff had been afforded due process of law.

Certainly the right to a jury trial and access to the judicial process are meaningless if the procedures afforded fail to give the litigants a complete opportunity to have their claims tried fairly and impar-

136. 576 N.E.2d 765 (Ohio 1991).

137. *Id.* at 771 (citation omitted).

138. 270 N.W.2d 125 (N.D. 1978).

139. *Id.* 137. In *Arneson*, the court was neither convinced that there was a medical insurance crisis sufficient to justify setting a cap on recoverable damages at three hundred thousand dollars nor of the opinion that the effect of the provision was to deny recovery to the most injured victims of medical malpractice. *Id.* at 136. The court also found that a provision of the medical malpractice statute prohibiting the joinder of medical care providers with non-medical practitioners was an unconstitutional delegation of judicial authority to establish rules of procedure. *Id.* at 131-32. The court also held unconstitutional a provision requiring a plaintiff to sue an insurance fund, and proceed without a jury trial, if the insurer for a named defendant paid a policy limit of one hundred thousand dollars (\$100,000.00) but the plaintiff demanded recovery beyond that amount. *Id.* at 137. The combination of these as well as additional suspect provisions led the court to declare the entire scheme unconstitutional. *Id.* at 138.

tially. Allowing evidence to be used only by one party and not by the other, without any sufficient articulable justification, would seem to make the proceedings constitutionally suspect. The problem is exacerbated by the fact that admissibility of the evidence could reasonably be predicted to alter the outcome of any given case. For these reasons, as well as for those implicating equal protection concerns, the exclusive use by defendants of evidence regarding compliance with practice guidelines may ultimately be held to be a violation of the Maine and Federal Constitutions.

VI. CONCLUSION

Since the mechanism of the affirmative defense in Maine's liability demonstration project has not been, and may not be, tested before the legislation expires, it is difficult to assess its practical effects. Analysis of the legislation suggests, however, at least three conclusions which can be drawn about its implications.

First, there is a narrow window of cases within which the affirmative defense of compliance with physician practice guidelines could achieve the legislation's goal of curtailing medical malpractice litigation.

Second, the mandatory application of the prelitigation screening panel process significantly undermines even the potential that the guidelines legislation will reduce the length and complexity of the defense of medical malpractice cases. The statutory requirements of the prelitigation screening panel process create a number of obstacles. The provisions contemplate full discovery on the negligence and causation issues which will ultimately be decided by the prelitigation screening panel. The panel is authorized to rule upon the affirmative defense of "compliance," yet its findings do not resolve the claim against the health care practitioner. Instead, if the findings are unanimous, they are admissible in a jury trial. In this case completion of the panel proceedings will not allow either party to avoid going forward to trial. The one possibility of early termination of the suit is through a motion for summary judgment. Even if this motion is filed during the screening panel stage, and heard by a superior court justice, it is extremely unlikely, given the factual nature of the circumstances surrounding the affirmative defense of compliance, that the motion would be granted. Thus, assertion of the defense will not protect physicians from having to undergo the prelitigation screening panel process or from having to defend claims at trial.

The third conclusion that can be drawn from the physician practice guidelines legislation is that it suffers from certain procedural shortcomings and, more importantly, from two potential constitutional infirmities. The statute does not negate the need for expert testimony at either the panel stage or at trial. In addition, in con-

junction with the prelitigation screening panel legislation, the statute contains a loophole through which plaintiffs can sidestep the restriction on the use of evidence regarding compliance with guidelines. The statute contemplates that evidence regarding compliance can be entered only by physician-defendants, not by plaintiffs. If the screening panel unanimously finds, notwithstanding a claim of compliance by a physician, that the physician breached the standard of care, then such evidence regarding the guideline and the failure to comply will be revealed to a jury at trial.

Absent a unanimous finding, the prohibition that prevents plaintiffs from using evidence regarding compliance with physician practice guidelines arguably amounts to a violation of the Equal Protection and Due Process Clauses of the Maine and United States Constitutions. Also potentially unconstitutional is that aspect of the legislation which bestows upon the prelitigation screening panel the authority to resolve the issue of the affirmative defense of compliance. If this provision is construed to deprive plaintiffs of either a summary judgment hearing on the affirmative defense or a jury trial in superior court, the statute should be deemed to violate the protections afforded under the Maine Constitution regarding a litigant's right to a full and fair trial before a jury.

The Maine legislature should amend the Demonstration Project and related statutory provisions. There are two effective ways to resolve the practical obstacles to meeting the goals of this enactment. One way would be to repeal the screening panel legislation, the other to create an exception to its application. Presumably the former is not feasible.¹⁴⁰ The latter would entail revising provisions such as section 2855 of the prelitigation screening panel legislation. For example, the provision could carve out an exception, triggered by a physician-defendant who is a participant in the Demonstration Project asserting compliance with guidelines as a defense in a medical malpractice case. Instead of a panel deciding, after a hearing, whether a defendant complied with a particular guideline, the matter would be removed from the panel process entirely to superior court for resolution either by summary judgment or trial. The parties could stipulate, or the court would have to find as a matter of law, that the physician-defendant was a participant in the Demonstration Project and that the statutorily adopted guidelines were applicable in the particular case.

In order to avoid the most critical constitutional infirmity in the Demonstration Project, section 2975(2) should be amended to allow both plaintiffs and defendants equal access to, and use of, evidence

140. It is beyond the scope of this Article to address whether the prelitigation screening panel legislation, aside from undermining the goals of the physician practice guidelines project, is an effective means of curtailing medical malpractice litigation.

regarding compliance with practice guidelines. Such an amendment would likely diminish the popularity of the legislation among the medical community. It should be recognized, however, that plaintiffs have access to guidelines other than those incorporated in the statute and could use them to measure a physician's adherence to an applicable standard of care. The statute does not protect physicians from the use of such other relevant evidence. Thus, treating physician-defendants equally with other litigants does not alter the playing field of medical malpractice litigation significantly.

If the Demonstration Project retains the one-sided use of physician practice guidelines and flaunts its potential constitutional flaw by allowing only physician-defendants to introduce evidence of compliance, then the prelitigation screening panel statute must be amended. As written, if there is a unanimous panel decision in a plaintiff's favor, notwithstanding a physician's claim of compliance with physician practice guidelines, the prelitigation screening panel statute requires jurors to be informed of the panel's unanimous results. Thus, plaintiffs ultimately are able to use the otherwise "forbidden" evidence. To protect the intent of the Demonstration Project, an exception to this provision is necessary. While such an amendment would resolve the inconsistency in the two legislative enactments, it also would exacerbate the constitutional problems which accompany the skewed use of evidence regarding physician practice guidelines. In the end, equal access to evidence by plaintiffs and defendants alike should be permitted.

