TORT REFORM AND MEDICAL MALPRACTICE: IOWA'S PAST, PRESENT, AND FUTURE

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I. Introduction

Increasing numbers of medical malpractice suits, increasingly large malpractice jury awards and increasing premiums with decreasing availability of liability insurance have created what many are terming a "crisis."[1] Debate on this issue is sharp:

> The insurance industry argues that the situation is the fault of activist judges and contingency fee plaintiffs' attorneys who have expanded the concept of liability for physical, emotional or financial injury beyond its traditional limits. Reform of the tort system is necessary, they argue, to alleviate the problems. Trial lawyers and consumer groups argue that the current situation is the fault of short-sighted insurance company executives who relied on high interest rates for their profit margins, rather than on sales of sound insurance policies. They argue that tighter regulation of the insurance industry is needed.[2]

The tort crisis is arguably most pronounced in the area of medical malpractice. Reports of physicians refusing to perform high-risk procedures, or manage labor and delivery are increasing.[3] Indeed, some jury verdicts are so high as to cause many physicians to ponder whether it is economically feasible to engage in the practice of medicine. One jury verdict well above the limits of a liability policy could destroy the assets that had been accumulated over a lifetime.

For example, a jury on the Ohio Court of Common Pleas recently

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1. *See, e.g. Torts Control*, Wall St. J., Feb. 4, 1986, at 24, col. 1 ("the torts system has gone berserk"); Reid, *Liability and the Insurance Shortage*, Wash. Post, Mar. 24, *Insurance: Hearings Before The U.S. House Committee on Public Works*, 99th Cong., 1st Sess. (1986).

2. Note, *The Current Status of Tort Reform in Iowa*, 35 Drake L. Rev. 859, 859 (1987) (citations omitted).

3. For example, on August 6, 1987 a seminar entitled "Crises in Obstetrics" was held in Clear Lake, Iowa. As one can imagine, the topics covered in the seminar included the high cost and unavailability of liability insurance, the decreasing number of physicians willing to perform obstetrics because of the associated liability, and the need for legislative responses.

awarded $7.3 million for brain damage to an infant when the defendant allegedly failed to take imperative measures to revive the child during delivery procedures.[4] In another case from North Dakota, a fetal monitor was not attached to a pregnant mother until one hour after she was admitted to the hospital, resulting in an alleged delay in diagnosing fetal distress.[5] The jury found the hospital liable and awarded $7,080,454 for the resulting brain damage.[6] Large verdicts are not confined to obstetrics. When a female in Alabama was prescribed aspirin that accumulated in her stomach due to a gastric blockage and later caused salicylate poisoning resulting in her blindness,[7] a jury awarded $8 million, including $3 million for her husband's loss of consortium of his 64 year old wife.[8] A Michigan jury awarded a plaintiff $5 million for failure to diagnose and treat head injuries necessitating surgery to remove blood clots and resulting in blindness and short term memory loss.[9] The 55 year old plaintiff fell hurting his head but was not admitted to the hospital until nearly a month later when he complained of feeling ill and was diagnosed as having the flu.[10]

This nationwide problem has been felt in Iowa. An Iowa Supreme Court study found that while the total number of liability lawsuits filed between 1980 and 1986 decreased by 12 percent, the number of medical malpractice cases doubled.[11] Iowa Insurance Commissioner William Hager has reported that the average liability verdict between 1980 and 1986, not including medical malpractice verdicts, was about $30,000.[12] The average medical malpractice verdict was almost $190,000 and there have been a number of multimillion dollar settlements.[13] Thirty percent of medical malpractice losses involve obstetric cure.[14] The Insurance Commissioner has also stated that obstetric services have been totally withdrawn in a number of Iowa's rural areas because "the obstetric portion of the medical malpractice premium charged for this state for many physicians exceeds the revenue they produce

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4. Hawkins v. Bedford Municipal Hospital, (Cleveland, Common Pleas #957, 170, Dec., 1986), *reported in*, 16 Personal Injury Verdict Reviews (June 15, 1987).

5. Nelson v. Trinity Medical Center, (Minot, N.D., U.S.D.C. #52430, July, 1986), *reported in*, 15 Personal Injury Verdict Reviews (March 16, 1987).

6. *Id.*

7. Davidson v. Mobile Infirmary, (Mobile, Ala. Circuit Court #CU78 001839, May, 1985), *reported in*, 14 Personal Injury Verdict Reviews (December 15, 1986).

8. *Id.* The total verdict was reduced to $1,350,000. *Id.*

9. Hollis v. North Detroit General Hospital, (Wayne County, Mich. Circuit Court, 3rd District, No. 83-307723, March, 1987), *reported in*, Medical Malpractice Verdicts, Settlements and Experts, Vol. 3, No. 8 at 8, (Aug. 1987).

10. *Id.*

11. Salmon, *Hager Says Malpractice Crisis is Real*, Bus. Rec., Aug. 17-23, 1987, at 1, col. 1.

12. *Id.*

13. *Id.*

14. *Id.*

from the deliveries themselves."[15]

Many feel the only realistic solution for this problem is to enact legislation to reform the tort system. This, however, involves a delicate balancing of competing interests. Persons injured through bona fide negligence of physicians are entitled to be recompensed for their legitimate injuries. This has been described as the primary function of tort law and the primary factor influencing its development.[16]

Remedial legislation cannot be designed merely to benefit physicians and health care institutions. The only appropriate goal of such action is to benefit society. The problem is society's problem. The lack of obstetrical care in rural Iowa is a problem for the people of Iowa as physicians. Any deterioration in the quality of this state's health care delivery system is a societal problem. The solution must be specifically and exclusively in the best interest of society. The Iowa General Assembly will have to keep this paramount as it considers appropriate remedial measures.

This is not to say that the Iowa legislature, and the judiciary, have not already attempted to address this situation. The Code of Iowa includes numerous provisions, enacted for the benefit of society, that impact on the tort system and medical malpractice litigation. Iowa courts have interpreted this state's common law to benefit society by balancing interests of injured plaintiffs and health care practitioners. The purpose of this article is to first review what the Iowa Legislature and courts have already done that affect medical malpractice; second, to review proposals for remedial legislation; and finally, to offer suggestions for appropriate future remedial measures.

II. Significant Statutory Provisions

The Code of Iowa currently contains a number of chapters that are designed to protect the public and/or provide some measure of protection for health care practitioners from legal liability for their actions. Some of these statutes have been enacted recently; some are quite old. But in one way or another, they modify tort common law and can be called "tort reform" measures.

A. *Licensure and Credentialing Physicians, Institutions and Health Care Practitioners*

Iowa currently has some form of legal credentialing for health care institutions, including hospitals,[17] residential care facilities,[18] intermediate

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15. *Id.*

16. W. Prosser & W. Keeton, The Law of Torts § 4, at 20 (5th ed. 1984)[hereinafter Prosser & Keeton].

17. Iowa Code ch. 135B (1987).

18. Iowa Code ch. 135C (1987).

care facilities,[19] and skilled nursing facilities.[20] It also licenses medical[21] and osteopathic[22] physicians,[23] as well as dentists,[24] chiropractors,[25] podiatrists,[26] and optometrists.[27]

Iowa also credentials other health care professionals who do not use the title "Doctor." These include nurses,[28] respiratory care practitioners,[29] nursing home administrators,[30] paramedics,[31] physical therapists,[32] occupational therapists,[33] physician's assistants,[34] dietitians,[35] ophthalmic dispensers,[36] hearing aid dealers,[37] psychologists,[38] social workers,[39] pharmacists and druggists,[40] and those who use X-ray equipment.[41]

Ostensibly, this regulation of professions is to protect the public from the incompetent or unethical practitioner or institution. If there were no regulation of various practices, the potential for "malpractice" by the unskilled and untrained would undoubtedly be significant. Through these laws, the state has taken some steps to assure that the incidence of unacceptable care is reduced by legally requiring demonstration of at least minimal competency.

In addition to the educational requirements to become initially licensed in these health care professions, the legislature has mandated continuing professional and occupational education as a requirement to maintain those licenses.[42] This is an effort to provide some assurance of continuing competence as scientific advances continue. Furthermore, the legislature has given all licensing boards specific authority to review and investigate acts or omissions, initiate and prosecute disciplinary proceedings, seek judicial enforce-

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19. *Id.*
20. *Id.*
21. IOWA CODE ch. 148 (1987).
22. IOWA CODE chs. 150, 150A (1987).
23. *See also* IOWA CODE chs. 147, 148D (1987).
24. IOWA CODE ch. 153 (1987).
25. IOWA CODE ch. 151 (1987).
26. IOWA CODE ch. 149 (1987).
27. IOWA CODE ch. 154 (1987).
28. IOWA CODE ch. 152 (1987).
29. IOWA CODE ch. 135F (1987).
30. IOWA CODE ch. 135E (1987).
31. IOWA CODE ch. 147A (1987).
32. IOWA CODE ch. 148A (1987).
33. IOWA CODE ch. 148B (1987).
34. IOWA CODE ch. 148C (1987).
35. IOWA CODE ch. 152A (1987).
36. IOWA CODE ch. 153A (1987).
37. IOWA CODE ch. 154A (1987).
38. IOWA CODE ch. 154B (1987).
39. IOWA CODE ch. 154C (1987).
40. IOWA CODE ch. 155 (1987).
41. IOWA CODE ch. 136C (1987).
42. IOWA CODE § 258A.2 (1987).

ment of its authority, and provide a variety of sanctions including revocation, suspension, probation, and civil penalties. In addition, specific education or examination is required.[43] This is more than just the profession policing itself because it brings in the authority of the state. These licensing boards are allowed to implement rules[44] which then carry the force of law.[45]

B. *"Good Samaritan" Laws*

Based on a Biblical parable of one who voluntarily rendered aid to an injured person,[46] the Good Samaritan Doctrine holds that "[o]ne who sees a person in imminent and serious peril through negligence of another cannot be charged with . . . negligence, as a matter of law, in risking his own life or serious injury in attempting to effect a rescue, provided the attempt is not recklessly or rashly made."[47] This limited immunity from liability is statutory in most states.[48]

Iowa, like most states, has a rather broad "Good Samaritan" statute:

> Any person, who in good faith renders emergency care or assistance without compensation shall not be liable for any civil damages for acts or omissions occurring at the place of an emergency or accident or while the person is in transit to or from the emergency or accident or while the person is at or being moved to or from an emergency shelter unless such acts or omissions constitute recklessness.[49]

In addition to this blanket provision, many statutes regulating specific health care professions also include Good Samaritan provisions.[50] These provisions are evidence of a public policy in Iowa to encourage those with special training and ability to render medical care in an emergency. Without this "reform" measure, an ungrateful victim of a life-threatening sickness or accident could sue a practitioner who attempted to provide assistance with no expectation of financial remuneration.

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43. *Id.* at § 258A.3. *See also id.* at §§ 258A.5, 258A.6, 258A.10.

44. *Id.* at 258A.5.

45. *See* Wagner v. Northeast Farm Serv. Co., 177 N.W.2d 1, 4 (Iowa 1970) (Administrative rules have the force and effect of laws).

46. *See Luke* 10:30-37.

47. BLACKS LAW DICTIONARY 624 (5th ed. 1979).

48. *Id.*

49. IOWA CODE § 613.17 (1987).

50. For example, a provision of the chapter regulating respiratory care practitioners states:

> A respiratory care practitioner who in good faith renders emergency care at the scene of an emergency is not liable for civil damages as a result of acts or omissions by the person rendering the emergency care. This section does not grant immunity from liability for civil damages when the respiratory care practitioner is grossly negligent.

IOWA CODE § 135F.10 (1987).

C. *Limitations of Actions*

Since medical malpractice insurance in Iowa generally provides coverage on a claims-made basis, health care institutions and practitioners must purchase an insurance "tail" which provides coverage for claims made for alleged negligence that occurred in prior years. If there were no statute of limitations for bringing medical malpractice claims, these institutions would need to purchase a "tail" to cover 40, 60 or more years, at astronomical cost. In fact, one of the reasons that malpractice insurance for obstetricians is so high is because they have to purchase a 20 year tail. This results from the statute of limitations being tolled during minority; so a baby born in 1987 can bring a malpractice action against the obstetrician in 2006.

To assure that hospitals and physicians don't have to defend lawsuits for acts or omissions that occurred in the distant past, there is an Iowa law limiting an action brought for malpractice.[51] This statute requires that malpractice actions be brought within two years after the occurrence.[52] The statute does, however, include a Discovery Rule which states the prospective plaintiff has two years after discovery of the alleged malpractice to bring the action.[53] In no event may the action be brought more than six years after the date of the act or omission.[54] But even this is not an absolute cut-off date. The six year limitation does not apply if a foreign object is unintentionally left in the body and causes injury or death.[55]

Basically, this means that practitioners who don't treat minors generally only need malpractice insurance with a six-year tail. Elimination of the Discovery Rule, so that insurance would only have to cover a two-year period for most health care practitioners, would further reduce the costs of insurance, which in turn should reduce health care costs.

D. *Statutory Privilege for Communications*

A communication to a physician or agent of a physician is privileged from disclosure, by common law in many states, but by statute in Iowa.[56] While probably not a tort-reform measure, this law does have some effect on the tort system. Without it, patients would be fearful to confide in physicians and physicians would be required to attempt to treat on the basis of less-than-complete information.

Far more important, in terms of tort reform, is the statutory privilege

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51. Iowa Code § 614.1(9) (1987).

52. *Id.*

53. *Id.* ("within two years after the date on which the claimant knew, or through the use of reasonable diligence should have known . . .").

54. *Id.*

55. *Id.*

56. Iowa Code § 622.10 (1987).

for peer review communications.[57] This provision prohibits disclosure of information given to peer review committees and peer review investigations and reports.[58] This serves several useful purposes. It allows a physician to consult with peers about his care and treatment of a particular patient. It also allows critical retrospective analysis of cases to learn better methods of treatment for the future. Similarly, it encourages peers to lodge complaints and initiate disciplinary action against those who are practicing substandard care, without fear of disclosure or retribution.

E. *Comparative Fault*

In *Goetzman v. Wichern*,[59] the Iowa Supreme Court discarded the old rule that a plaintiff's contributory fault was a complete bar to recovery and adopted pure comparative fault.[60] This resulted in a situation where a plaintiff who was 90% at fault for his own $1 million injury could sue a doctor who was 10% at fault and recover $100,000. Many considered this inequitable and called for reform. The legislature responded by passing a comparative fault act.[61] Essentially, the legislation overruled *Goetzman* in part and adopted a modified comparative fault system for Iowa. Now a plaintiff cannot recover damages unless the combined fault of all defendants and persons released exceeds the plaintiff's percentage of fault.[62] This is a more equitable system. A plaintiff cannot recover from a defendant when the plaintiff is more at fault; but when a defendant is required to pay damages, those damages are reduced in proportion to the plaintiff's fault.[63]

This legislation also modified the rule of joint and several liability. Prior to this reform, one defendant who was only 5% at fault could be required to pay 100% of damages if the co-defendants had no means to pay their share. This fundamentally unfair system was corrected by a rule that no defendant shall be required to contribute more to the damages than his share of fault, unless that defendant was responsible for 50% or more of the fault.[64]

F. *Other Recent Statutory Provisions*

In addition to the legislative enactments previously covered, the Iowa General Assembly has in recent years enacted a variety of statutes that are

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57. *Id.* at § 147.135 (1987).

58. *Id.* ("Peer review records are privileged and confidential, are not subject to discovery, subpoena, or other means of legal compulsion . . .").

59. 327 N.W.2d 742 (Iowa 1983).

60. *Id.*

61. IOWA CODE ch. 668 (1987). This was adopted in 1984. Act approved May 17, 1984, ch. 1293, 1984 IOWA ACTS 524.

62. IOWA CODE § 668.3(1) (1987).

63. *Id.*

64. *Id.* at § 668.4

relevant here. The principal changes deal with punitive damage awards, informed consent, abrogation of the Collateral Source Rule, expert witnesses, and review of contingent fee arrangements.

1. *Punitive Damages*

In 1986, a new law was enacted which dealt with punitive damage awards.[65] Perhaps as a reaction to, or fear of, excessive jury awards of punitive damages,[66] this reform was passed.

Under the new law, a jury must answer two special interrogatories whenever punitive damages are requested: whether the defendant's conduct constituted willful and wanton disregard for the rights or safety of another; and whether this conduct was directed specifically at the plaintiff.[67] Willful and wanton disregard is required before punitive damages can be awarded.[68]

If the willful and wanton conduct was directed toward the claimant, then the full amount of punitive damages shall be paid to the claimant.[69] If, however, the conduct was not directed specifically at the claimant, then the court may order up to 25% of the punitive damage award paid to the claimant; but the balance of the award is to be paid into a civil reparations trust fund.[70]

2. *Informed Consent*

An increasing number of lawsuits claiming that physicians were treating without obtaining a truly "informed" consent prompted the legislature to pass legislation dealing specifically with that issue. Under this law, a written consent to any medical or surgical procedure creates a statutory presumption that an informed consent was given if the written consent:

> 1. [s]ets forth in general terms the nature and purpose of the procedure or procedures together with the known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures, with the probability of each such risk if reasonably determinable[,] 2. [a]cknowledges that the disclosure of that information has been made and that all questions asked about the procedure or procedures have been answered in a satisfactory manner[, and,] 3. [i]s signed by the pa-

65. Act approved May 22, 1986, ch. 1211, § 42, 1986 IOWA ACTS 313 (codified as amended at IOWA CODE ch. 668A (1987)).

66. For example, a trial court jury in California awarded $125 million in punitive damages in one case involving the Pinto automobile. *See* Grimshaw v. Ford Motor Co., 119 Cal. App. 3d 757, 174 Cal. Rptr. 348 (1981)(All but $3.5 million of punitive damages remitted as a condition for denial of new trial - affirmed).

67. IOWA CODE § 668A.1(1)(1987).

68. *Id.* at § 668A.1(2).

69. *Id.*

70. *Id.*

> tient for whom the procedure is to be performed, or if the patient for any reason lacks legal capacity to consent, is signed by a person who has legal authority to consent on behalf of that patient in those circumstances.[71]

Although this presumption is probably rebuttable, informed consent lawsuits could be reduced to a minimum if physicians would tailor their consent forms to meet the statutory requirements.

3. *Abrogation of Collateral Source Rule*

The general rule in the tort system is that a plaintiff's recovery is not reduced by any amount that is indemnified or replaced by insurance, governmental programs or otherwise.[72] This principle is known as the Collateral Source rule.[73] Since most medical malpractice plaintiffs have health insurance or can obtain government-paid health care, malpractice verdicts for past and future medical expenses, etc., have often resulted in a type of double recovery.

This problem was resolved by a "reform" measure that legislatively abrogated the Collateral Source Rule in medical malpractice cases.[74] It states that:

> The damages awarded shall not include actual economic losses incurred or to be incurred in the future by the claimant by reason of the personal injury, including but not limited to, the cost of reasonable and necessary medical care, rehabilitation services, and custodial care, and the loss of services and loss of earned income, to the extent that those losses are replaced or are indemnified by insurance, or by governmental, employment, or service benefit programs or from any other source except the assets of the claimant or of the members of the claimant's immediate family.[75]

4. *Expert Witnesses*

In response to claims that attorneys were using witnesses as "experts" who had little or no expertise in matters about which they were testifying, the legislature in 1986 passed some expert witness standards.[76] This new statute states:

> If the standard of care [of] a physician and surgeon . . . or a dentist . . . is at issue, the court shall only allow a person to qualify as an expert

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71. *Id.* at § 147.137.

72. *See generally* 22 AM. JUR. 2d *Damages* § 206, at 286-87 (1965).

73. BLACKS LAW DICTIONARY 238 (5th ed. 1979).

74. *See* IOWA CODE § 147.136 (1987).

75. *Id.* This statute survived a constitutional challenge in *Rudolph v. Iowa Methodist Medical Center*, 293 N.W.2d 550 (Iowa 1980).

76. Act approved May 22, 1986, ch. 1211, § 16, 1986 IOWA ACTS 307 (codified at Iowa Code § 147.139 (1987)).

> witness and to testify on the issue of the appropriate standard of care if the person's medical or dental qualifications relate directly to the medical problem or problems at issue and the type of treatment administered in the case.[77]

This helps to assure that bona fide experts are used to demonstrate an alleged deviation from the standard of care. Since that standard must be proven by expert testimony,[78] a statutory definition of who qualifies as an expert on a particular issue was needed. A plaintiff who cannot locate an expert who meets these qualifications probably has no merit to his or her claim.

In addition, there are new statutory deadlines for disclosure of expert witnesses in professional liability cases brought against licensed health care professionals.[79] The plaintiff now must disclose expert witnesses within 180 days after the defendant's answer and the defendant must disclose within 90 days after the plaintiff's disclosure.[80]

5. *Contingent Fee Review*

A little-used provision of the Code of Iowa allows the court to review the reasonableness of any contingent fee arrangement between the plaintiff and his attorney in a medical malpractice action.[81] Defendants will perhaps begin to use this law when they attempt to settle a case and encounter a plaintiff who is reluctant to settle, knowing 40% of the settlement amount will go to his attorney.

III. Significant Judicial Actions

In addition to the statutory enactments that have had some effect on the tort recovery system, there have been changes in the Iowa common law that would have to be considered tort reforms. While many of these judicial actions are longstanding and may be traced back to the Common Law of England, some are relatively recent.

A. *Definition of Malpractice*

There is no statutory definition of malpractice. But for the Iowa common law, developed through case law, there would be no tort of medical malpractice. Malpractice is negligence by a professional.[82] Generally, the ele-

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77. Iowa Code § 147.139 (1987).

78. *E.g.*, Bryant v. Rankin, 332 F. Supp. 319 (S.D. Iowa 1971), *aff'd*, 468 F.2d 510 (8th Cir. 1972).

79. *See* Iowa Code § 668.11 (1987).

80. *Id.*

81. Iowa Code § 147.138 (1987).

82. *See* Blacks Law Dictionary 864 (5th ed. 1979).

ments of negligence are duty, breach, proximate cause, and damage.[83] A *prima facie* case of medical malpractice requires that a plaintiff present evidence that establishes the applicable standard of care, that the standard has been violated, and that there is a causal relationship between the violation and an injury.[84]

To maintain a medical malpractice action in Iowa, the plaintiff must demonstrate an affirmative act of negligence, a lack of skill or care, or a failure to give careful and proper attention to the patient.[85] While the result of the treatment administered to the plaintiff by the defendant is not in itself evidence of negligence, it has been held to be a circumstance that may be considered by the jury in determining whether the result is attributable to negligence by the defendant.[86]

Without these judicially-imposed definitions of malpractice, health care institutions and professionals may have been subjected to something akin to strict liability: liability without fault whenever there is an unfortunate result. The definition of malpractice absolved a professional from liability when his conduct conforms to the standard of care for that profession. As long as medicine continues to be more of an art than an exact science, this will continue to be necessary.

B. *Standard of Care*

1. *Generally*

The test of whether a physician (or any medical professional) is negligent is whether the physician did what an ordinary physician of good standing would have done under like circumstances.[87] The Iowa Supreme Court expressed the standard of care for physicians as a requirement to use "that degree of knowledge, skill, care and attention ordinarily exercised by physicians under like circumstances and in like localities."[88]

"A patient is entitled to [as] thorough and careful [an] examination . . . as his condition [warrants] and . . . circumstances will permit, with such diligence and methods of diagnosis as are usually approved and practiced by physicians of ordinary skill and learning under like circumstances and in like localities."[89] The list of Iowa cases defining the standard of care for

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83. PROSSER & KEETON, *supra* note 16, § 30, at 164-65 (5th ed. 1984).

84. Daboll v. Hoden, 222 N.W.2d 727, 734 (Iowa 1974).

85. Lagerpusch v. Lindley, 253 Iowa 1033, 1037, 115 N.W.2d 207, 210 (1962).

86. *See, e.g.*, Daiker v. Martin, 250 Iowa 75, 81, 91 N.W.2d 747, 750 (1958); Kirchner v. Dorsey & Dorsey, 226 Iowa 283, 295, 284 N.W. 171, 178 (1939); Berg v. Willett, 212 Iowa 1109, 1112, 232 N.W. 821, 823 (1931); Shockley v. Tucker, 127 Iowa 456, 458, 103 N.W. 360, 360 (1905).

87. Freese v. Lemmon, 267 N.W.2d 680, 688 (Iowa 1978).

88. Bartholomew v. Butts, 232 Iowa 776, 779, 5 N.W.2d 7, 9 (1942).

89. Freese v. Lemmon, 267 N.W.2d at 688; Sinkey v. Surgical Assoc., 186 N.W.2d 658, 660 (Iowa 1971); *see also*, Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966); McGulpin v.

medical care practitioners is lengthy.[90]

Formerly an Iowa physician was merely held to the standard of medical care practiced in his community.[91] That rule, however, has been abolished and the locality where the physician practices is merely one circumstance the jury may consider, not an absolute limit upon the skill required.[92]

A physician who holds himself out to be a specialist is held to a higher standard of care than a nonspecialist. A specialist is required to use that degree of ordinary care and skill exercised by similar specialists under similar conditions and not merely the average care and skill of a general practitioner.[93]

Other medical practitioners, such as osteopathic physicians[94] and dentists[95] are required to observe the standards of similar professionals under similar circumstances. It is generally accepted that Allopaths and Osteopaths are held to the same standards of care. A chiropractor is generally held to a standard of care of other chiropractors under similar circumstances. However, when a chiropractor goes beyond his field and enters into the practice of medicine, he may be held to the standard of care and skill exercised by medical doctors.[96]

There are two standards of care for Iowa hospitals, based upon whether the hospital is providing professional care, or nonmedical ministerial care. In *Dickinson v. Mailliard*,[97] the Court rejected the "community standard rule"

Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950).

90. *See, e.g.*, Freese v. Lemmon, 267 N.W.2d 680 (Iowa 1978); Speed v. State, 240 N.W.2d 901 (Iowa 1976); Perin v. Hayne, 210 N.W.2d 609 (Iowa 1973); Sinkey v. Surgical Assoc., 186 N.W.2d 658 (Iowa 1971); Kastler v. Iowa Methodist Hosp., 193 N.W.2d 98 (Iowa 1971); Dickinson v. Mailliard, 175 N.W.2d 588 (Iowa 1970); Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966); Johnson v. Van Werden, 255 Iowa 1285, 125 N.W.2d 782 (1964); Correll v. Goodfellow, 255 Iowa 1237, 125 N.W.2d 745 (1964); Barnes v. Bovenmeyer, 255 Iowa 220, 122 N.W.2d 312 (1963); Wheatley v. Heideman, 251 Iowa 695, 102 N.W.2d 343 (1960); Daiker v. Martin, 250 Iowa 75, 91 N.W.2d 747 (1958); Christensen v. Des Moines Still College of Osteopathy & Surgery, 248 Iowa 810, 82 N.W.2d 741 (1957); McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950); Wilson v. Corbin, 241 Iowa 593, 41 N.W.2d 702 (1950); Wambold v. Brock, 236 Iowa 758, 19 N.W.2d 582 (1945); Bartholomew v. Butts, 232 Iowa 776, 5 N.W.2d 7 (1942); Kirchner v. Dorsey & Dorsey, 226 Iowa 283, 284 N.W.2d 171 (1939); Forrest v. Abbott, 219 Iowa 664, 259 N.W. 238 (1935); Berg v. Willett, 212 Iowa 1109, 232 N.W.2d 821 (1930); Ramberg v. Morgan, 209 Iowa 474, 218 N.W. 492 (1928).

91. *See, e.g.*, Bartholomew v. Butts, 232 Iowa 776, 5 N.W.2d 7 (1942).

92. Speed v. State, 240 N.W.2d 901 (Iowa 1976) (overruling in part *Sinkey v. Surgical Assoc.*, 186 N.W.2d 658 (Iowa 1971)).

93. *See, e.g.*, O'Brien v. Stover, 443 F.2d 1013, 1017 (8th Cir. 1971); Perin v. Hayne, 210 N.W.2d 609, 615 (Iowa 1973) (neurosurgeon); Barnes v. Bovenmeyer, 255 Iowa 220, 228, 122 N.W.2d 312, 316 (1963) (eye specialist); McGulpin v. Bessmer, 241 Iowa 1119, 1132, 43 N.W.2d 121, 128 (1950) (expert on treatment of varicose veins).

94. *See, e.g.*, Wheatley v. Heideman, 251 Iowa 695, 704, 102 N.W.2d 343, 349 (1960).

95. *See, e.g.*, O'Brien v. Stover, 443 F.2d 1013 (8th Cir. 1971); Wambold v. Brock, 236 Iowa 758, 19 N.W.2d 582 (1945); Whetstine v. Moravec, 228 Iowa 352, 291 N.W. 425 (1940).

96. Correll v. Goodfellow, 255 Iowa 1237, 1245, 125 N.W.2d 745, 749 (1964).

97. 175 N.W.2d 588 (Iowa 1970).

that had previously been applied and instead held hospitals to what other hospitals under similar circumstances would do.[98] With respect to nonmedical, administrative, ministerial or routine care for patients hospitals are held to a standard of care as the patient's known mental and physical condition may require.[99]

If it were not for these judicially defined standards of care, a jury would have no guidance in determining whether there has been negligent action. This helps avoid the unrealistic but otherwise possible scenario of a jury holding a general practitioner treating headaches to the standard of a neurosurgeon.

This definition of standard of care also helps prevent a practitioner from being held liable for merely making a wrong diagnosis, after a thorough and competent examination. For example, in *Sinkey v. Surgical Associates*,[100] the treating doctor was not negligent when he misdiagnosed the patient's appendicitis as tonsillitis after a competent examination showing symptoms consistent with tonsillitis.[101]

2. *Expert Testimony*

In most situations, Iowa common law requires that evidence of the requisite skill and care to be exercised by health care professionals must be established by experts.[102] Experts may express their opinion as to probable or possible causation.[103] The opinion may reach the ultimate legal or factual issue in the case.[104]

The Iowa Supreme Court has only recognized two situations where expert testimony is not required to establish evidence of malpractice: when the lack of due care was so obvious as to be within the comprehension of the average layperson and when an unrelated part of the body is injured.[105] These two exceptions to the general rule requiring expert testimony may

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98. *Id.* at 596-97. *Accord* Clites v. State, 322 N.W.2d 917 (Iowa Ct. App. 1982). *See also* Speed v. State, 240 N.W.2d 901 (Iowa 1976).

99. Bradshaw v. Iowa Methodist Hosp., 251 Iowa 375, 101 N.W.2d 167 (1960) (negligence for leaving patient unattended). *See also* Kastler v. Iowa Methodist Hosp., 193 N.W.2d 98 (Iowa 1971).

100. 186 N.W.2d 658 (Iowa 1971).

101. *Id. Cf.* Speed v. State, 240 N.W.2d 901 (Iowa 1976).

102. Bryant v. Rankin, 332 F. Supp. 319 (S.D. Iowa 1971), *aff'd*, 486 F.2d 510 (8th Cir. 1972); Buckroyd v. Bunten, 237 N.W.2d 808 (Iowa 1976); Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966); Bartholomew v. Butts, 232 Iowa 776, 5 N.W.2d 7 (1942); Jackovach v. Yocom, 212 Iowa 914, 237 N.W. 444 (1931); Ramberg v. Morgan, 209 Iowa 474, 218 N.W. 492 (1928).

103. Dickinson v. Mailliard, 175 N.W.2d 588 (Iowa 1970).

104. Iowa R. Evid. 704.

105. *See* Forsmark v. State, 349 N.W.2d 763 (Iowa 1984); Buckroyd v. Bunten, 237 N.W.2d 808 (Iowa 1976); Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966).

only be used when something is drastically wrong with the care provided.[106]

If the failure or lack of care is so obvious that the average layperson can understand and appreciate it, expert testimony is not required. This is not a broad exception. In *Johnson v. Van Werden*,[107] for example, it was held that the appearance of blisters after a traction bandage was removed did not indicate so obvious a lack of care as to negate the need for expert testimony.[108] As a general practice, expert testimony will be required to establish that there has been a deviation from the standard of care.

It is somewhat easier to get a case submitted without expert testimony if an area of the body is injured that is not part of the area under treatment. In *Wiles v. Myerly*,[109] no expert testimony was required when burns on the buttocks occurred while undergoing chest treatment.[110] This exception does not apply, however, when the injury occurs to a portion of the body that is within the surgical field.[111] In *Forsmarak v. State*,[112] the exception was not applicable when the patient suffered a spinal cord contusion during a laminectomy.[113]

The rule requiring expert testimony may well serve to reduce the number of frivolous claims. If a plaintiff cannot find even one expert who will state that there has been a deviation from the standard of care, then the plaintiff does not have a meritorious claim.

As a practical matter, an attorney should never file a lawsuit against a health care provider or institution without first having an opinion from a qualified expert that the applicable standard of care has been violated.

3. *Abandonment*

A physician who undertakes charge of a patient's case must follow the case and give proper instructions to the patient as to his further acts and

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106. *See* Daiker v. Martin, 250 Iowa 75, 91 N.W.2d 747 (1958) (leg cast too tight; cut off circulation to foot resulting in amputation); Frost v. Des Moines Still College, 248 Iowa 294, 79 N.W.2d 306 (1956) (burns on abdomen while anesthetized for back surgery); Evans v. Roberts, 172 Iowa 653, 154 N.W. 923 (1915) (part of tongue cut off while removing adenoids). *Cf.* McCleary v. Wirtz, 222 N.W.2d 409 (Iowa 1974) (insufficient evidence when no expert testimony as to what caused gangrene in leg cast).

107. 255 Iowa 1285, 125 N.W.2d 782 (1964).

108. *Id. See also* O'Brien v. Stover, 443 F.2d 1013 (8th Cir. 1971); Forsmark v. State, 349 N.W.2d 736 (Iowa 1984); Kastler v. Iowa Methodist Hosp., 193 N.W.2d 98 (Iowa 1971); Sinkey v. Surgical Associates, 186 N.W.2d 658, 661 (Iowa 1971) (and cases cited therein).

109. 210 N.W.2d 619 (Iowa 1973).

110. *Id. See also* Frost v. Des Moines Still College, 248 Iowa 294, 79 N.W.2d 306 (1956)(burns on abdomen; back surgery).

111. Forsmark v. State, 349 N.W.2d 763 (Iowa 1984); Perin v. Hayne, 210 N.W.2d 610 (Iowa 1973).

112. 349 N.W.2d 763 (Iowa 1984).

113. Removal of material between bones of the spine. *Id. See also* Perin v. Hayne, 210 N.W.2d 610 (Iowa 1973) (exception did not apply where patient suffered paralyzed larynx during anterior cervical fusion—surgery required retraction of laryngeal nerve).

conduct.[114] A physician who abandons a patient in a critical stage of treatment without valid reasons and without sufficient notice so as to allow the patient to secure alternative services is liable for dereliction of duty.[115]

A physician's employment continues until ended by mutual consent or his services are no longer needed. Leaving a patient in a critical stage of pathology may be a culpable dereliction of duty in breach of a contract,[116] but it is more likely a violation of the standard of care which is negligence.[117]

4. *Duty to Refer to Specialists*

Health care practitioners have a judicially-created duty to refer some patients and conditions to specialists.[118] There is no strict requirement to refer patients, but consultation with specialists is expected when diagnosing and treating some conditions where expertise may be lacking.

In *Wheatley v. Heideman*,[119] an osteopathic physician was held liable when expert testimony demonstrated that ordinarily a general practitioner in the community would not undertake to sew up a cut in the eyelid, but would send the child directly to a specialist to determine if there was damage to the eye itself.[120] Also, in *Speed v. State*,[121] an oral surgeon was found negligent in failing to obtain assistance from doctors in other areas of practice when confronting an unexpected situation.[122]

C. *Res Ipsa Loquitur*

Res Ipsa Loquitur is a doctrine which allows an injured party to recover damages in some situations when he cannot prove specific acts of negligence.[123] The Iowa Supreme Court has identified its role in medical malpractice cases:

> [W]hen res ipsa is submitted in a medical malpractice case, the plaintiff is relieved of the burden of showing that specific acts of defendant were

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114. Barnes v. Bovenmeyer, 225 Iowa 220, 122 N.W.2d 312 (1963).

115. *Id.*

116. McGulpin v. Bessmer, 241 Iowa 1119, 43 N.W.2d 121 (1950).

117. *See* Smith v. Lerner, 387 N.W.2d 576 (Iowa 1986).

118. Speed v. State, 240 N.W.2d 901 (Iowa 1976); Wheatley v. Heideman, 251 Iowa 695, 102 N.W.2d 343 (1960); Nelson v. Sandel, 202 Iowa 109, 209 N.W. 440 (1926).

119. 251 Iowa 695, 102 N.W.2d 343 (1960).

120. *Id.*

121. 240 N.W.2d 901 (Iowa 1976).

122. *Id.*

123. The classic example is *Byrne v. Broadle*, 2 H&C. 722, 159 Eng. Rep. 299 (Court of Exchequer 1863), where a person was injured by a barrel of flour that fell from a window in the defendant's warehouse. Recovery was allowed even though the plaintiff could not prove any negligence because it is fairly obvious that barrels don't roll out of windows without someone being negligent—the thing speaks for itself. *Id.*

> below accepted medical standards. The plaintiff still must prove negligence, but he or she does so by convincing the jury the injury would not have occurred absent some unspecified but impliedly negligent act.[124]

There are two elements that must be met before a case can be submitted to the jury in Iowa. These are: (1) exclusive control and management of the instrumentality which caused the injury complained of by the person charged with negligence, and (2) an occurrence causing the type of an injury that, in the ordinary course of events, would not have happened if reasonable care had been used.[125] If either element is absent, the doctrine does not apply.[126]

The Court has narrowly applied the doctrine. First, the Court has said numerous times that this doctrine should be used very rarely in medical cases.[127] It has, however, been applied where several physicians share control or where an assistant or employee is negligent.[128] Second, it has been held that element (1) is frequently not met because the patient's frailties, idiosyncrasies, physical and mental weaknesses, and allergies are instruments over which the physician does not have control.[129]

Finally, the doctrine is inapplicable if risks are inherent in the medical procedure and the injury is of a type that may occur despite due care by the defendant.[130]

In sum, the Iowa Supreme Court has taken an evidentiary doctrine, long applicable in other negligence actions, and made it narrowly applicable in medical negligence cases.

D. *Guarantee/Warranty of Results*

Iowa common law is clear that a physician does not impliedly guarantee or warrant a cure or even the best possible result merely by agreeing to undertake treatment.[131] A physician does not even impliedly guarantee that his

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124. Sammons v. Smith, 353 N.W.2d 380, 385 (Iowa 1984).

125. *Id.*; Cronin v. Hagan, 221 N.W.2d 748, 751 (Iowa 1974); Wiles v. Myerly, 210 N.W.2d 619, 624-25 (Iowa 1973); Perin v. Hayne, 210 N.W.2d 609, 614 (Iowa 1973); Mogensen v. Hicks, 253 Iowa 139, 110 N.W.2d 563, 565 (1961).

126. Cronin v. Hagan, 221 N.W.2d at 751, Wiles v. Myerly, 210 N.W.2d at 625; Lagerpusch v. Lindley, 253 Iowa 1033, 1038, 115 N.W.2d 207, 210 (1962); Mogensen v. Hicks, 253 Iowa at 143, 110 N.W.2d at 565.

127. *E.g.*, Lagerpusch v. Lindley, 253 Iowa at 1038, 115 N.W.2d at 210; Mogensen v. Hicks, 253 Iowa at 143, 110 N.W.2d at 565.

128. *See* Sammons v. Smith, 353 N.W.2d at 387-88.

129. Sammons v. Smith, 353 N.W.2d at 386-87; Wiles v. Myerly, 210 N.W.2d at 627; Lagerpusch v. Lindley, 253 Iowa at 1038, 115 N.W.2d at 210; Mogensen v. Hicks, 253 Iowa at 143-44, 110 N.W.2d at 565-66; Berg v. Willett, 212 Iowa 1109, 232 N.W. 821 (1930).

130. *E.g.*, Cronin v. Hagan, 221 N.W.2d at 753; Wiles v. Myerly, 210 N.W.2d at 625; Perin v. Hayne, 210 N.W.2d at 615.

131. Berg v. Willett, 212 Iowa 1109, 232 N.W. 821 (1931); Hair v. Sorenson, 215 Iowa 1229, 247 N.W. 651 (1933); Nelson v. Sandell, 202 Iowa 109, 209 N.W. 440 (1926).

treatment will be beneficial.[132]

However, a physician may expressly warrant or contract to cure or obtain a specified result and such contract or express warranty may be binding.[133] In some cases what a physician may regard as therapeutic reassurance may be assumed by the patient to be a warranty of results and thus enforceable.[134]

This doctrine does not insulate a physician from a duty to disclose possible unfortunate results.[135] A physician is, nonetheless, entitled to an instruction to the jury that "a physician does not impliedly warrant a cure or guarantee the best result" in actions based on claims of warranty or specific acts of malpractice in the diagnosis or treatment of the patient.[136]

This common law provision limits the number of claims that would otherwise be filed each time the best possible result was not obtained.

E. *Informed Consent*

Although the doctrine of informed consent has been previously discussed in reference to a legislative enactment,[137] it should be remembered that this duty to make reasonable disclosure to a patient of the nature and probable consequences of medical treatment was judicially created.[138] If a physician performs treatment without consent, or obtains consent for one type of treatment and subsequently performs a substantially different treatment, there is a clear case of battery.[139] If, however, an undisclosed complication results, which was a known risk, the failure to obtain informed consent is negligence.[140]

Before 1987, Iowa common law had two informed consent rules. The "Professional Rule" applied to nonelective surgery and required physicians to disclose not all risks but those deemed important.[141] Complete disclosure of all material risks was required in elective surgery for socio-economic reasons and was called the "Patient Rule."[142]

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132. Gephardt v. McQuillen, 230 Iowa 181, 297 N.W. 301 (1941).

133. *See generally* Annotation, *Measure and Elements of Damages in Action Against Physician for Breach of Contract to Achieve Particular Result or Cure*, 99 A.L.R.3d 303 (1980).

134. *See* Perin v. Hayne, 210 N.W.2d 609, 616 (Iowa 1973).

135. Moser v. Stallings, 387 N.W.2d 599, 604 (Iowa 1986).

136. *Id.*

137. *See supra* note 70 and accompanying text.

138. Grosjean v. Spencer, 258 Iowa 685, 140 N.W.2d 139 (1966)(adopting the leading case of *Natanson v. Cline*, 186 Kan. 393, 350 P.2d 1093 (1960)).

139. Perin v. Hayne, 210 N.W.2d 609, 617-18 (Iowa 1973).

140. *Id.*

141. *See id.*; Grosjean v. Spencer, 258 Iowa at 693-94, 140 N.W.2d at 144-45.

142. Cowman v. Hornaday, 329 N.W.2d 422 (Iowa 1983).

In *Pauscher v. Iowa Methodist Medical Center*,[143] the "Professional Rule" was abolished.[144] Now full disclosure of all risks a patient would consider material is required.[145] Although *Pauscher* appears to increase the exposure of health care practitioners to lack of informed consent claims, the decision does have some "tort reform" aspects.

First, the decision clarifies that hospitals and other institutions have no duty to obtain the consent; it is a physician's duty.[146]

Also, *Pauscher* identified six exceptions to the rule:

> 1. Situations in which a complete and candid disclosure might have a detrimental effect on the physical or psychological well-being of the patient;
> 2. Situations in which a patient is incapable of giving consent by reason of mental disability or infancy;
> 3. Situations in which an emergency makes it impractical to obtain consent;
> 4. Situations in which the risk is either known to the patient or is so obvious as to justify a presumption on the part of the physician that the patient has knowledge of the risks;
> 5. Situations in which the procedure itself is simple and the danger remote and commonly appreciated to be remote;
> 6. Situations in which the physician does not know of an otherwise material risk and should not have been aware of it in the exercise of ordinary care.[147]

These exceptions clarify when physicians must obtain an informed consent. By following the statutory requirements in all other cases,[148] physicians can create a presumption of informed consent.

F. *Respondeat Superior*

Basically, the *Respondeat Superior* Doctrine holds the master liable for the wrongful acts committed by his servant in the scope of his employment.[149] In Iowa, the doctrine is often used to hold a physician liable for the negligence of persons assisting him in the diagnosis and treatment of a patient or to hold a hospital liable for negligence of its employees.

In *Wiles v. Myerly*,[150] an anesthesiologist was held liable for the negligence of temporary assistants, including nurses and interns, who assisted in

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143. 408 N.W.2d 355 (Iowa 1987).
144. The Professional Rule was "inherently paternalistic and authoritarian in nature." *Id.* at 358.
145. *Id.* at 359.
146. *Id.* at 362.
147. *Id.* at 360.
148. Iowa Code § 147.137 (1987).
149. Blacks Law Dictionary 1179 (5th ed. 1981).
150. 210 N.W.2d 619 (Iowa 1973).

the course of an operation.[151] In *Lambert v. Sisters of Mercy Health Corp.*,[152] a hospital was held liable for the negligence of a nurse who failed to inform the attending physician of a patient's condition.[153]

The attending physician, however, is probably not liable for the negligence of an independent consulting physician.[154] There is no master-servant relationship between the two. Also, most hospital staff physicians are independent contractors and their negligence is not generally imputed to the hospital.[155] The Court has said that in some circumstances, a hospital can be held accountable for a staff doctor's negligence.[156] This might occur, for example, if a hospital were negligent in granting staff privileges.[157]

Respondeat superior is a means to shift liability from those who probably cannot pay a judgment, such as nurses and technicians, to those who have deep pockets, such as physicians and hospitals. While the basic fairness of the system may be arguable, the system is likely to remain for some time.

G. *Statutes of Limitations*

Both the Legislature and the Judiciary have impacted upon the law governing the period in which one must bring an action for medical negligence.[158] Originally there was a two-year statute of limitations. However, in *Chrischilles v. Griswold*,[159] the Iowa Supreme Court adopted a discovery rule.[160] This allowed a plaintiff two years from the time the plaintiff knew or reasonably should have known of negligence.[161]

The Legislature codified that rule,[162] but strictly limited the discovery period by setting an outside limit of six years.[163] The Court determined that this limitation period is tolled in favor of a minor for one year after the minor reaches the age of majority.[164]

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151. *Id.*

152. 369 N.W.2d 417 (Iowa 1985).

153. *Id. See also* Schnebly v. Baker, 217 N.W.2d 708 (Iowa 1974); Frost v. Des Moines Still College, 248 Iowa 294, 79 N.W.2d 306 (1956).

154. *See* Nelson v. Sandell, 202 Iowa 109, 209 N.W. 440 (1926) (doctor who referred patient to dentist and assisted dentist not liable for dentist's negligence).

155. *E.g.*, Sinkey v. Surgical Associates, 186 N.W.2d 658 (Iowa 1981), *overruled*, Speed v. State, 240 N.W.2d 901 (Iowa 1976); Dickinson v. Mailliard, 175 N.W.2d 588 (Iowa 1970).

156. Dickinson v. Mailliard, 175 N.W.2d at 594.

157. *See* Annotation, *Hospital's Liability for Negligence in Selection or Appointment of Staff Physician or Surgeon*, 51 A.L.R.3d 981 (1973).

158. *See* IOWA CODE § 614.1(9) (1987).

159. 260 Iowa 453, 150 N.W.2d 94 (1967).

160. *Id.*

161. *Id.*

162. IOWA CODE § 614.1(9) (1987).

163. *Id.*

164. Kohrt v. Yetter, 344 N.W.2d 245 (Iowa 1984).

H. *Damages*

A final area of the medical malpractice recovery system that has been touched by the Iowa Judiciary is that of damages. Not only has the common law of this state been defined to specify what must be proven to enable a plaintiff to recover damages, the courts have also identified some so-called "torts" for which no damages are recoverable. The Iowa Supreme Court also created a fundamental change in the damage recovery system when it adopted comparative fault.

1. *Prima Facie Case*

A "prima facie case of medical malpractice must normally consist of evidence which establishes the applicable standard of care, demonstrates that this standard has been violated, and develops [sic] a causal relationship between the violation and the harm complained of."[165] These three elements are a predicate for the recovery of damages.

Thus a plaintiff is precluded from recovering damages if he fails to demonstrate the standard of care and a violation thereof. A physician or hospital could commit an egregious violation of the standard of care, but if it produced no injury, there can be no recovery. The whole theory of the tort recovery system is to compensate the injured party for injuries sustained.[166] As long as humans are involved in the delivery of health care, some errors are going to be unavoidable. As long as those errors cause no injury to anyone, there should be no payment of damages.

2. *Cause of Action for Stillborn Fetus*

The Iowa Supreme Court prevented an expansion of the class of potential medical malpractice plaintiffs when it decided *Weitl v. Moes*[167] in 1981. The Court held "that a fetus, whether viable or not, is not a 'person' within the meaning" of an Iowa Code section allowing recovery for damages for wrongful death.[168] This reaffirmed a prior holding that no wrongful death action may be maintained on behalf of a fetus.[169]

These decisions place Iowa in the minority since approximately two thirds of the states allow recovery for wrongful death of a fetus.[170] In some respects this is a tort "reform" decision. *Weitl* does not preclude the mother

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165. Daboll v. Hoden, 222 N.W.2d 727, 734 (Iowa 1974). *See also* Moore v. Guthrie Hosp., Inc., 403 F.2d 366, 367-68 (4th Cir. 1968); Kosberg v. Washington Hosp. Center, Inc., 394 F.2d 947, 949 (D.C. Cir. 1968).

166. PROSSER & KEETON, *supra* note 16, § 1 at 5-6.

167. 311 N.W.2d 259 (Iowa 1981), *overruled*, Audubon-Exira Ready Mix Inc. v. Illinois Cent. Gulf R.R., 335 N.W.2d 148 (Iowa 1983).

168. *Id.* at 273. *See* IOWA CODE § 611.20 (1987).

169. McKillip v. Zimmerman, 191 N.W.2d 706 (Iowa 1971).

170. *See* Weitl v. Moes, 311 N.W.2d at 270-71 & n.5.

of the stillborn fetus from recovering damages for her physical and mental injuries.

3. *Damages for Wrongful Life*

In another somewhat "reform" measure, the court in *Nanke v. Napier*[171] refused to allow parents of a normal child to bring an action for wrongful life after a failed abortion.[172] Thus negligence in performing an abortion does not give rise to an action to recover the costs of rearing a *healthy* child.[173]

> This conclusion is based on the public policy of Iowa which dictates that a parent cannot be said to have been damaged or injured by the birth and rearing of a normal, healthy child because the invaluable benefits of parenthood outweigh the mere monetary burdens as a matter of law.[174]

4. *Comparative Fault*

Although the law of Iowa on comparative fault is statutory,[175] it should be remembered that the adoption of comparative fault, as a tort reform measure, was done judicially. In *Goetzman v. Wichern*,[176] the Iowa Supreme Court abolished contributory fault as a complete bar to recovery and established a system of "pure" comparative negligence.[177] This allowed each party's recovery of damages to be reduced proportionately to that party's responsibility for them.[178]

Goetzman v. Wichern made it much easier for plaintiffs to recover damages, but it also contained at least some implication that co-defendants would bear the responsibility to pay damages for only their proportion of fault.[179] At any rate, *Goetzman* was the stimulus for the Legislature to pass chapter 668, which includes a provision that a defendant who is less than 50% at fault is not jointly and severally liable for all of the damages.[180]

IV. Possible Future Reform

Because the area of medical malpractice law is broad and the entire tort recovery system is embroiled in controversy, prediction of future reforms is difficult. Specific tort reforms tend to be similar from state to state, and

171. 346 N.W.2d 520 (Iowa 1984).
172. *Id.* at 523.
173. *Id.* This is the majority rule. *Id.* at 522.
174. *Id.* at 522-23.
175. *See* Iowa Code ch. 668 (1987).
176. 327 N.W.2d 742 (Iowa 1983).
177. *Id.* at 754.
178. *Id.*
179. *See id.* at 755 (Carter, J., dissenting).
180. *See* Iowa Code § 668.4 (1987).

reports, articles and proposals dealing with reform are on the rise. It is reasonable to look at national trends and popular proposals to determine what problems the Iowa Legislature might attack next.

Iowa, as aforementioned, has already implemented a number of reforms. In 1986, the Liability and Liability Insurance Study Commission of Iowa issued a Final Report[181] pointing the way to several possible reforms. Pending before the Iowa House is legislation which has already been approved by the Iowa Senate that would drastically alter our medical malpractice law.[182]

When the recent and prior reforms in this state and others are reviewed, a picture of proposed reforms emerges.

Worth noting is Senate File 484, the Health Care Provider and Patient Assistance Act.[183] The bill is modeled after the Nebraska Hospital-Medical Liability Act.[184] In the preamble, the legislature states that it is attempting to address two major concerns. First, that physicians in high risk areas are "ceasing to provide health care services."[185] The second concern is that health care providers are practicing defensive medicine by ordering tests and procedures that are unnecessary.[186] Defensive medicine drives up health care costs with no counterbalancing benefit.[187] The bill sums up the legislature's concerns:

> The general assembly finds that a critical situation exists in Iowa's health care provider industry impacting on the accessibility and affordability of high-quality health care.[188]

The legislation concludes that it must assure high-quality medical and hospital services be available to Iowa citizens at reasonable cost.[189]

Both the proposed Iowa Health Care Provider and Patient Assistance Act and the Nebraska Plan provide for a limitation on recovery, an excess liability fund. Various other reforms have been, and may be, considered.

A. *Limits on Damage Recoveries*

As one commentator has noted, "[t]he quintessential aspect of medical

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181. The references here are to the PRELIMINARY DRAFT OF THE FINAL REPORT OF THE LIABILITY AND LIABILITY INSURANCE STUDY COMMISSION (December 15, 1986)[hereinafter FINAL REPORT]. The Commission was composed of four senators, four representatives, four public members, and the Attorney General and Insurance Commissioner as ex officio member.

182. S.F. 484, 73rd Gen. Assem. (1988)[hereinafter S.F. 484].

183. *Id.*

184. NEB. REV. STAT. §§ 44-2801 to 44-2855 (1984).

185. S.F. 484, *supra* note 182.

186. *Id.*

187. *Id.*

188. *Id.*

189. *Id.*

malpractice tort reform is a statutory limit or 'cap' on recoveries."[190] In Iowa, caps on recovery are often discussed and proposed. The legislature, in Senate File 484, has proposed various sums[191] and may alter the bill further as it proceeds through the legislative process. The suggested limit is generally one million dollars.[192] It is unclear whether this is intended as a total limit.[193] In addition, if the amount of the judgment exceeds one million dollars, the court may structure the payments in such a way that the total payment is close to the actual verdict.[194]

Proposals for recovery caps will probably persist because they pose a simple, straightforward remedy to the tort crisis. Major plans like the Nebraska Plan include caps.[195] Yet the results from such caps are inconclusive.[196] Indeed, it is unclear whether caps are even designed to resolve any of the problems underlying the so-called crisis.[197]

Critics of caps generally rely on statistics pointing out the small numbers of large verdicts. For example, only 5.6 percent of settlements and verdicts are for more than $100,000 in noneconomic damages.[198] The small number of cases resulting in high damages causes some critics to assert that it would make much more sense to prevent low-dollar recoveries rather than place caps at high levels.[199] In addition to the alleged ineffectiveness, there is a very serious concern with limits which might deny just compensation to injured parties.[200]

Despite these criticisms, caps appear in both the GAO report[201] and the Iowa tort reform report.[202] Senate File 484 contains a damage cap[203] and a

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190. Fieger, *Medical Malpractice Tort Reform: An Analysis and Comparison of Existing Acts*, *66* MICH. BAR J. 262, 262 (1987).

191. S.F. 484, supra note 182.

192. *Id.*

193. *Id.* The amount is stated as though it were a total cap on damages, and the act follows the Nebraska Act generally. Nebraska's cap is total. NEB. REV. STAT. § 44-2825 (1984).

194. The statute is difficult to understand on this point. Presumably, if actual damages exceeded the cap (presently $1,000,000), a $1,000,000 lump sum judgment would be the best award because the present value of money is always greater than future value of the same amount. *See* S.F. 484, *supra* note 182.

195. *See* NEB. REV. STAT. § 44-2825 (1984).

196. *Compare* UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION 27 (May 1987) (caps reduce average claims)[hereinafter GAO Report] *with* Saks, *Medical Malpractice Litigation: Who Needs Reform?*, 26 IOWA ADVOC. 27, 28 (Spring/Summer 1987) [hereinafter Saks] and Phillips, *Tort Reform and Insurance Crisis in the Second Half of 1986*, 22 GONZ. L. REV. 277, 288 (1986-87).

197. Saks, *supra* note 196, at 28.

198. GAO Report, *supra* note 196, at 27.

199. Saks, *supra* note 196, at 28.

200. *See, e.g.*, Carson v. Maurer, 424 A.2d 825 (N.H. 1980); Moskal & Berge, *Tort "Reform": Minnesota Does Not Need Legislation that Makes Victims Pay for the Negligence of Others*, 13 WM. MITCHELL L. REV. 347 (1987).

201. GAO Report, *supra* note 196, at 28.

202. FINAL REPORT, *supra* note 181.

203. S.F. 484, *supra* note 182.

cap was endorsed by Insurance Commissioner Bill Hager.[204] Part of the reason for these proposals is that in the few cases with large damages, most of the damage award is noneconomic. One study reported that noneconomic damages represented, on average, 80 percent of the total awards in the 5.6 percent high damage cases mentioned above.[205] These cases are also the high-visibility cases which are easy to connect with the general rise in insurance premiums.

Statistics from the Iowa Tort Liability Study prepared by the National Center for State Courts[206] reveal that Iowa awards in medical malpractice cases follow the national trends. Only six medical malpractice damage awards exceeded $250,000 between 1980 and May 1986,[207] thus a cap like the proposed $1,000,000 in Senate File 484 might have little immediate impact. Indeed, the cap is higher than the highest award which was $880,000.[208]

However, it is nearly impossible to gather statistics regarding settlements because they are often kept private by agreement. It is reasonable to assume that some high risk cases are settled to avoid high damages. A cap would give those parties a lower point at which to start bargaining and could bring down settlements.

In addition, caps can bring down the average medical malpractice award by lowering high claims.[209] The GAO report on medical malpractice states that the effect of caps in place has been to reduce the average claim paid by twenty three percent.[210] In Iowa where the average medical malpractice award is $187,510,[211] lowering the average award may be justified, but it will take a more stringent cap than $1,000,000.

Given the wide range of support, caps will continue to be proposed and may well be implemented. However, caps have received mixed reviews under state constitutions. Simply passing caps does not insure long life. Caps have been struck down under both intermediate and strict scrutiny.[212] On the other hand, caps have been upheld in some states.[213] The variation from

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204. Salmon, *supra* note 11.

205. GAO Report, *supra* note 196, at 27.

206. National Center for State Courts, Iowa Tort Liability Study: Draft Report (September 13, 1986)[hereinafter Iowa Tort Liability Study].

207. *Id.*

208. *Id.*

209. GAO Report, *supra* note 196, at 27.

210. *Id.*

211. Iowa Tort Liability Study, *supra* note 206.

212. *See, e.g.*, Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980); Wright v. Central Depage Hosp. Assoc., 63 Ill. 2d 313, 347 N.E.2d 736 (1976); Baptist Hosp. of Southeast Texas v. Baber, 672 S.W.2d 296 (Tex. App. 1984); Duren v. Suburban Community Hosp., 482 N.E.2d 1384 (Ohio 1985).

213. *See, e.g.*, Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1976); Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665, 211 Cal. Rptr. 368 (1985); Johnson v.

state to state makes predicting the outcome in any one state difficult.[214] There is no doubt, however, any cap would be challenged in court.

B. *Excess Liability Fund*

Senate File 484 is modeled after the Nebraska Plan, which has resulted in lower premiums for doctors in all specialties.[215] This is only partially due to its $1,000,000 cap. In addition to the cap, Nebraska developed an excess liability fund to cover large damage cases.[216]

A physician in Nebraska must only be insured up to $200,000 per occurrence ($600,000 per year).[217] The excess liability fund covers damages over $200,000 and up to the $1,000,000 limit.[218] The fund is financed by a surcharge to physicians of up to fifty percent of their insurance premiums.[219] Even with the surcharge, Nebraska physicians pay significantly less in malpractice insurance than Iowans.[220] For example, an Iowa obstetrician/gynecologist would pay $59,472[221] for comparable coverage that would cost a Nebraska physician $38,472.[222] Actually, the Iowa physician would pay even more because few Iowa physicians will settle for $1 million in coverage.[223]

Thus, the combination of a cap plus the excess liability coverage may significantly reduce the cost of insurance to a physician. Since the legislature's stated concern is to alleviate a critical situation in which quality health care is becoming unaffordable,[224] it is likely that it will give serious consideration to a similar bill.

Various versions of Senate File 484 place the insurance limit in Iowa at $100,000[225]—even lower than Nebraska's. Whether a fifty percent surcharge on this lower coverage will be enough to finance the excess liability fund is one key question the legislature will be required to address. However, the package of caps with the fund would provide relief to physicians by lowering their premiums, if the fund is fiscally sound.

St. Vincent Hosp., Inc., 273 Ind. 374, 404 N.E.2d 585 (1980).

214. An example of the difficulties is found in an attempt to balance the cases cited in notes 212 and 213 in determining the constitutionality of Michigan's reform statute. Fieger, *Medical Malpractice Tort Reform: An Analysis and Comparison of Existing Acts*, 66 MICH. BAR J. 262 (March 1987).

215. IOWA MEDICAL SOCIETY, MALPRACTICE INSURANCE PREMIUMS: NEBRASKA AND IOWA COMPARED (March 1987)[hereinafter IOWA MEDICAL SOCIETY].

216. NEB. REV. STAT. §§ 44-2829-44-2833 (1984).

217. *Id.* § 44-2827 (Supp. 1986).

218. *Id.* § 44-2829 (1984).

219. *Id.* § 44-2829(2).

220. IOWA MEDICAL SOCIETY, *supra* note 215.

221. *Id.*

222. *Id.*

223. *Id.*

224. S.F. 484, *supra* note 182.

225. *Id.*

C. *Other Nebraska Plan Reforms*

The Nebraska plan contains several other reforms which will probably be considered for inclusion in an Iowa version. A medical review panel can be used to review Nebraska malpractice claims and make recommendations which are then admissible in court.[226] Patients can opt out of the requirements of the act by notifying the State Director of Insurance of their intent to be covered by the act and provide proof of insurance as well as pay into the excess liability fund.[227]

Because the Nebraska plan is a complete package and because Senate File 484 tracks the language of Nebraska's Statute very closely, it is likely that the Iowa bill will be accepted or rejected as a package. If Iowa adopts the cap and excess liability fund, it will probably also add the opt-out provisions and the medical review panel.

D. *Statutes of Limitations*

A frequently mentioned reform, especially in the area of obstetrics and gynecology where premiums are increasing rapidly, is a shortened limitations period.[228] Usually, this is proposed as a limit on the discovery rule. Though Iowa has already adopted a limit in medical malpractice actions, as discussed above, the six-year outside limit does not apply to children bringing malpractice actions based on problems at birth.[229]

The statute of limitations is tolled by the minority of the child, and does not run until one year after majority is attained.[230] Thus, a child could have up to nineteen years to file a so-called "bad baby" case.[231]

This length of time causes particular difficulty with insuring OB/GYN's because of the difficulty in predicting the length of time for coverage under "occurrence" policies.[232] Under "claims made" policies, doctors are forced to insure themselves for a lengthy time after they leave the practice.[233] This expensive tail of the policy period has been criticized for escalating the cost of OB/GYN malpractice insurance.[234]

One faction criticizing the existence of the tail was a minority of the Iowa Tort Liability Study group in a separate statement.[235] According to this group, actions against all doctors should be restricted to a set period of

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226. NEB. REV. STAT. §§ 44-2840, 44-2844(2) (1984).
227. *Id.* § 44-2824.
228. *See, e.g.*, FINAL REPORT, *supra* note 181, (Minority Report by Eversman)
229. IOWA CODE § 614.8 (1987).
230. *Id.*
231. *Id.*
232. Salmon, *supra* note 11; Abraham, *Making Sense of the Liability Insurance Crisis*, ___ OHIO ST. L.J. ___ (1987) (Draft at 15).
233. GAO Report, *supra* note 196, at 21-22.
234. *Id.*
235. FINAL REPORT, *supra* note 181.

time.[236] The minority opinion pointed out that although six members of the group agreed, seven votes were required to adopt the recommendation.[237]

If the legislature remains true to its stated goal of assuring health care in specific areas which are now threatened, it probably should adopt some restrictive measures in these cases. The present limit of nineteen years has been much criticized and doctors in this area have been particularly hard-hit by increasing insurance costs.

Some problems could be caused by restricting these actions. Because minors are not allowed to file suit, a limitation which shortens the period for actions to less than the child's minority could be open to due process challenge.[238] The Iowa Supreme Court has not addressed the issue.[239]

E. *Sliding Scale for Contingency Fees*

Though neither the Iowa Liability and Liability Insurance Study Commission nor Senate File 484 contain any recommendations regarding attorney's fees, the area draws much attention. The Liability Commission specifically rejected fee regulation because fees are private contractual matters between an attorney and client.[240]

On the other hand, the GAO report recommends retention of contingent fees within limits[241] because the system "enables injured parties without resources to obtain access to the legal system."[242] Furthermore, the system provides incentives to attorneys to get the best possible awards or settlements while discouraging frivolous suits.[243]

Without diminishing that incentive, restrictions on fees in high damage award cases would "provide a greater proportion of award or settlements to the injured patients, reduce legal costs associated with pursuing malpractice cases, and encourage plaintiff lawyers to settle larger cases sooner."[244] The report recommended a sliding scale similar to the one used in California.[245]

California allows 40 percent for the first $50,000, 33 ⅓ percent for the next $50,000, 25 percent for the second $100,000, and 10 percent for any

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236. *Id.*

237. *Id.*

238. *See, e.g.*, Strahler v. St. Luke's Hosp., 706 S.W.2d 7 (Mo. 1986); Barrio v. Sam Manuel Division Hosp., 143 Ariz. 101, 692 P.2d 280 (1984); Sax v. Votteler, 648 S.W.2d 661 (Tex. 1983). A similar challenge has been raised in Iowa against the former 60-day notice provision of the municipal tort claims act. Brief for Appellant at 6-22, Miller v. Boone Co. Hosp., 394 N.W.2d 776 (Iowa 1986).

239. Miller v. Boone Co. Hosp., 394 N.W.2d at 777 n.2.

240. FINAL REPORT, *supra* note 181.

241. GAO Report, *supra* note 196, at 24.

242. *Id.* at 23.

243. *Id.* at 24.

244. *Id.*

245. *Id.*

amount over $200,000.[246] The report further noted that the Attorney General's Tort Policy Working Group recommended 25 percent for the first $100,000, 20 percent for the second $100,000, 15 percent for the third $100,000, and 10 percent for any amount over $300,000.[247]

Under the Attorney General's recommendation, an attorney would receive $130,000 for a $1 million award. This allows over $200,000 more to go to the injured party than a standard one-third contingency fee would, while providing a sizable sum to the attorney as compensation.

The plaintiffs' bar argues that contingent fees encourage attorneys to take only worthy cases. A claimant's loss results in no fee with additional loss of out-of-pocket expenses and the possibility of an exposure to sanctions or disciplinary action. No lawyer is going to work on a case that has no merit. Thus frivolous suits should not be brought if attorneys adequately review and investigate cases before filing suit.

Most individuals cannot afford to hire a lawyer on an hourly charge bases. Contingency fees afford an injured person opportunity to hire a competent lawyer.

Lawyers working on contingency earn nothing until the case is finally resolved. Medical negligence lawsuits often require months or years to prepare and try with very expensive payments for travel, experts and depositions. Lengthy appeals often follow jury verdicts.

Defense lawyers are paid at a set hourly rate and, generally, on an interim basis throughout the course of the lawsuit.

The reasonableness of all contingency arrangements in actions for personal injury or wrongful death against health care providers are to be reviewed by the court.[248] Thus, the Court can adjust fees which are unfair or inequitable on a case by case basis.

V. Conclusion

Reforms are in order. It is impossible to get a consensus on the extent of the problem, who or what is at fault, or specific solutions.

The issue is complex. Civil justice reform issues are being discussed in nearly every state legislature across the country. In addition, the Reagan administration has appointed a task force which has recommended that Congress enact reforms at the federal level which would pre-empt state laws.

There are no quick or easy solutions. Neither lawyers, physicians, nor insurance companies are popular. No single group or specific problem is the cause for the current problem. Each group feels that the figures stated and the facts relied upon by others are inaccurate or misleading.

The tremendous recent strides and successes of the health professions

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246. *Id.*
247. *Id.* at 25.
248. Iowa Code § 147.138 (1987).

in keeping people alive and saving lives have also led to increased lawsuits and potential liability. Public expectation is often unrealistic. Many now expect a perfect result, so when a defective child is born the response is to blame the doctor. Doctors do perform negligently on occasion. Yet, too often, the incompetent doctors are not the ones who get sued. The public must understand and accept that not all bad results are malpractice.

No matter what solutions are tried, our jury system must be preserved. The tort system, though flawed, is one of the primary protections for victims of medical negligence.

Certainly changes in the insurance industry and more careful monitoring by doctors of competence in the profession are necessary.

It is inevitable that caps or limitations will be placed on non-economic awards for pain and suffering, mental distress and punitive damages.

Time and further study will, hopefully, reveal the actual causes of the current insurance and liability problem. Lawyers can provide the most immediate and significant solution. No lawsuit against a health care provider should be brought unless the facts and issues involved have been thoroughly investigated, studied and reviewed by the injured party's lawyer and a competent and qualified expert. Lawyers who file professional negligence claims without fully informed expert support should be subject to harsh sanctions.