

1990

Medical Professional Liability and the Delivery of Obstetrical Care

Roger J. Bulger

Victoria P. Rostow

Follow this and additional works at: <https://scholarship.law.edu/jchlp>

Recommended Citation

Roger J. Bulger & Victoria P. Rostow, *Medical Professional Liability and the Delivery of Obstetrical Care*, 6 J. Contemp. Health L. & Pol'y 81 (1990).

Available at: <https://scholarship.law.edu/jchlp/vol6/iss1/8>

This Article is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Journal of Contemporary Health Law & Policy (1985-2015) by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE

*Roger J. Bulger, M.D.**
*and Victoria P. Rostow, J.D.***

On October 11, 1989, the Institute of Medicine of the National Academy of Sciences released the results of a two-year study investigating the effects of medical professional liability on the delivery of obstetrical care.¹ This report, and its companion volume of supporting material, set forth the deliberations of an interdisciplinary committee of fourteen experts. To carry out its objectives, the committee commissioned more than twenty papers from distinguished specialists in various fields, commissioned three surveys to gather new data, and reviewed more than fifty state and national surveys.² As part of its data collection, the committee held an interdisciplinary symposium on June 20, 1988, at which seventeen scholars assessed the impact of professional liability issues on access to and delivery of obstetrical care in the United States.³

As the chairman and the study director of the interdisciplinary committee, we evaluated the available data on professional liability in obstetrics, reflected on its implications, and are pleased to have this opportunity to share the committee's findings. This Article has two purposes: 1) to describe the findings and recommendations of the committee regarding the impact of professional liability in obstetrics; and 2) to offer personal reflections regard-

* President, Association of Academic Health Centers and Chairman of the Institute of Medicine's Committee on The Effects of Medical Professional Liability on Obstetrics.

** Director, Committee on the Effects of Medical Professional Liability on Obstetrics and Attorney, Washington, D.C.

The authors are also editors of *Medical Professional Liability and the Delivery of Obstetrical Care, vol. II: An Interdisciplinary Review* which is a collection of papers presented at a symposium on professional liability in obstetrics held at the National Academy of Sciences on June 20, 1988. This article is based on the material presented in that volume, as well as in the Institute of Medicine report, *Professional Liability and the Delivery of Obstetrical Care*, vol. 1.

1. INSTITUTE OF MEDICINE, 1 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE (1989).

2. *Id.* at viii.

3. 2 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE: AN INTERDISCIPLINARY REVIEW (R. Bulger & V. Rostow 1989) [hereinafter MEDICAL PROFESSIONAL LIABILITY].

ing the importance of preserving the integrity of the physician-patient relationship in the delivery of obstetrical care.

What became known in many quarters as "the medical malpractice crisis" first captured public attention in the mid-1970's. At that time, a series of reports indicated that growing numbers of medical malpractice suits, with ever increasing awards, were prompting increases in malpractice insurance premiums.⁴ These prohibitive costs, in some instances, made insurance unavailable.⁵

By 1987, when the Institute of Medicine began to study the effects of medical professional liability on the delivery of obstetrical care, it was clear that the malpractice problem not only had defied treatment in the previous decade, but had been exacerbated. Any momentum achieved toward solving the problem had been lost, and the progress of the academic literature on malpractice issues and reforms was at a standstill.⁶ Moreover, the debate over public policy had become narrowly focused on tort reform.⁷ To be sure, a few scholars were proposing theoretical alternatives to the tort system for the compensation of victims of medical malpractice.⁸ Although alternative systems were being debated in scholarly journals, however, there had been little practical experience with them.⁹

In addition, certain facts had changed in the decade since the ills related to professional liability were first diagnosed in the American health care delivery system. By 1987, the media was focusing on reports of obstetricians, family physicians, and nurse-midwives who had abandoned obstetrical practice, leaving segments of the population without adequate care.¹⁰ Although many readily accepted that issues of professional liability posed a problem in the delivery of obstetrical care in the United States, little was known about the problem's practical dimensions or what to do about it.¹¹

Early in its deliberations, the Institute of Medicine's study committee focused on access to obstetrical care and delivery and analyzed proposed solutions to the problem of medical professional liability from the perspective of obstetrics. Its reasons were twofold. First, obstetrics claims represented approximately ten percent of all medical malpractice claims nationwide and

4. *Id.* at ix.

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

nearly half of all indemnity payments.¹² Second, the committee firmly believed that in order to move the public policy debate toward a productive resolution, it was necessary to arrive at a consensus about the practical dimensions of the problem and to analyze thoroughly the options available to solve it. Because of the availability of data, obstetrics presented the committee with a unique opportunity. The committee hopes that its findings will have wide relevance to issues of medical professional liability in general, but has taken great care to restrict its recommendations to obstetrical care.¹³

While recognizing that several major forces are altering the provision of health care in the United States, the committee concluded that the problem of professional liability adversely affects the delivery of obstetrical services, especially to disadvantaged women, those living in rural areas, and those with high-risk pregnancies.¹⁴ Obstetricians and family physicians increasingly report that they are eliminating the obstetrical portion of their practices or reducing the provision of care to patients who are identifiably at high risk because they fear being sued and do not want to accept the high cost of liability insurance.¹⁵ Reducing care for high-risk women affects the entire population, but it has a special impact on low-income patients.¹⁶ Surveys conducted by state medical societies indicate that the percentage of obstetricians and gynecologists who report a reduction in the provision of care to high-risk women because of concern about professional liability ranges from sixteen to forty-nine percent.¹⁷ This range is consistent with the rates reported by the American College of Obstetricians and Gynecologists in 1987, that twenty-seven percent had reduced or eliminated high-risk care.¹⁸ According to surveys undertaken by the National Governors Association in all fifty states, sixty percent of Medicaid programs and almost ninety percent of maternal and child health programs are having trouble ensuring the participation of maternity care providers in sufficient numbers.¹⁹ Nine out of ten report that the rising costs of malpractice insurance have contributed to

12. GENERAL ACCOUNTING OFFICE, *MEDICAL MALPRACTICE: SIX STATE CASE STUDIES SHOW CLAIMS AND INSURANCE COSTS STILL RISE DESPITE REFORMS* (1986).

13. INSTITUTE OF MEDICINE, *supra* note 1, at viii.

14. *Id.* at 7.

15. *Id.* at 38. Evidence indicates that "physicians are stopping obstetrical practice at an earlier point in their careers in response to professional liability concerns." *Id.* (emphasis added).

16. *Id.* at 59.

17. *Id.* at 39-40.

18. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG), *PROFESSIONAL LIABILITY INSURANCE AND ITS EFFECTS: REPORT OF A 1987 SURVEY OF ACOG'S MEMBERSHIP 22* (1988) [hereinafter 1987 SURVEY].

19. INSTITUTE OF MEDICINE, *supra* note 1, at 59 (citing NATIONAL GOVERNORS' ASSOCIATION, CENTER FOR POLICY RESEARCH, HEALTH POLICY STUDIES, *Increasing Provider*

their problems.²⁰ Both data from state medical societies and surveys conducted by the American Academy of Family Physicians confirm that the attrition rate among family physicians who provide obstetrical care is especially high, creating a shortage of obstetrical services in rural areas.²¹ The same problems have affected the organization and practice of nurse-midwifery.²²

With regard to trends in malpractice insurance and their implications, the committee noted that obstetrical claims are more numerous and more severe than those in other specialties, and that these differences recently have been magnified.²³ Today, professional-liability insurance is available to the practicing physician, as it was not during the crisis of the 1970s. However, its cost and affordability are problematic. According to data from the American Medical Association and analyses performed specifically for the committee, rising premiums have been linked to increasing fees in obstetrical practice.²⁴ Nevertheless, although increases in fees have not quite kept pace with increases in premiums, obstetricians' incomes have tended on average to remain constant over the past few years.²⁵ These national statistics mask huge variations among the providers of obstetrical care in various regions of the country and with different levels of experience. The committee found no support in studies by the General Accounting Office, the Florida Academic Task Force for Review of the Insurance and Tort Systems, the New York State Department of Insurance, and the Tort Policy Working Group (an interagency working group of the federal government) for the argument that excessive profit-taking by malpractice insurers has been a major contributor to the malpractice problem in obstetrics.²⁶ According to these reports, the

Participation: Strategies for Improving States Perinatal Programs (1988) [hereinafter NATIONAL GOVERNORS' ASSOCIATION]].

20. INSTITUTE OF MEDICINE, *supra* note 1, at 59. There is also a widespread belief, for which the committee found no substantiating evidence, that the poor are more litigious than the middle and upper classes. *Id.* at 64.

21. See generally AMERICAN ACADEMY OF FAMILY PHYSICIANS, *THE FAMILY PHYSICIAN AND OBSTETRICS: A PROFESSIONAL LIABILITY STUDY* (1986); AMERICAN ACADEMY OF FAMILY PHYSICIANS, *FAMILY PHYSICIANS AND OBSTETRICS: A PROFESSIONAL LIABILITY STUDY* (1987).

22. INSTITUTE OF MEDICINE, *supra* note 1, at 50-51.

23. *Id.* at 2.

24. *Id.* See Reynolds, Rizzo & Gonzalez, *The Cost of Medical Professional Liability*, 257 J. A.M.A. 2776, 2779 (1987).

25. See generally AMERICAN MEDICAL ASSOCIATION, CENTER FOR HEALTH POLICY RESEARCH, *SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE* (1987).

26. The Institute of Medicine examined the following policies: GENERAL ACCOUNTING OFFICE, *INSURANCE: PROFITABILITY OF THE MEDICAL MALPRACTICE AND GENERAL LIABILITY LINES* (1987); FLORIDA ACADEMIC TASK FORCE FOR REVIEW OF THE INSURANCE AND TORT SYSTEMS, *PRELIMINARY FACT-FINDING REPORT ON MEDICAL MALPRACTICE*

principal factors in the growth of malpractice premiums appear to be changes in the frequency and severity of claims and lower interest rates, which have reduced the insurers' investment income.²⁷

The available data supported the conclusion that the cost of malpractice insurance further reduced the already low Medicaid participation rates of obstetrical providers in most jurisdictions.²⁸ According to a study commissioned by the committee and conducted by the Children's Defense Fund, the allocated cost of insurance exceeded Medicaid's reimbursement rate in most areas.²⁹ Medicaid reimbursement rates were lower than malpractice premiums alone, not counting other overhead costs, in eight of the forty states included in the study.³⁰ In Illinois, Missouri, and New Jersey, premium costs were more than \$240 higher than the reimbursement rate.³¹ Moreover, another survey commissioned by the committee revealed that concern about liability adversely affected the provision or purchase of obstetrical services in community and migrant health centers.³²

Concerned about the rising rate of cesarean deliveries, the committee examined the available survey data and commissioned papers on both cesarean deliveries and electronic fetal monitoring.³³ The committee concluded that among the several reasons for the rising rate of cesarean deliveries are concern about malpractice suits and a subsequent excessive reliance on the results of electronic fetal monitoring.³⁴ Routine electronic monitoring in normal and high-risk pregnancies and deliveries is now the standard; providers who do not use it flirt with the danger of a major suit should an infant be brain damaged, despite the growing body of evidence that such unfortunate

(1987); DEPARTMENT OF JUSTICE, TORT POLICY WORKING GROUP, AN UPDATE ON THE LIABILITY CRISIS (1987); NEW YORK STATE GOVERNOR'S ADVISORY COMMITTEE ON LIABILITY INSURANCE, INSURING OUR FUTURE: REPORT OF THE GOVERNOR'S ADVISORY COMMITTEE ON LIABILITY INSURANCE (1986). See also INSTITUTE OF MEDICINE, *supra* note 1, at 114-15.

27. INSTITUTE OF MEDICINE, *supra* note 1, at 114-15.

28. See *id.* at 54-72; NATIONAL GOVERNORS' ASSOCIATION, *supra* note 19.

29. INSTITUTE OF MEDICINE, *supra* note 1, at 60-62.

30. *Id.* at 61-62.

31. *Id.* at 61.

32. *Id.* at 65-66.

33. *Id.* at 75-82. See also Thacker, *The Impact of Technology Assessment and Medical Malpractice on the Diffusion of Medical Technologies: The Case of Electronic Fetal Monitoring*, in 2 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE: AN INTERDISCIPLINARY REVIEW 9 (R. Bulger & V. Rostow 1989); Sachs, *Is the Rising Rate of Cesarean Sections a Result of More Defensive Medicine?*, in 2 MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE: AN INTERDISCIPLINARY REVIEW 27 (R. Bulger & V. Rostow 1989).

34. INSTITUTE OF MEDICINE, *supra* note 1, at 75-76.

outcomes are seldom linked to birth events.³⁵ Not only has medical science failed to determine the cause of cerebral palsy, but studies to date do not support the view that electronic fetal monitoring is effective in identifying or preventing it.³⁶ Thus, the committee concluded that Americans have adopted electronic monitoring as standard practice, at considerable added expense to routine obstetrical care, despite the failure of scientific evidence to support its use.³⁷

In an informal survey of one hundred thirty-two academic department chairpersons of obstetrics and gynecology conducted by the committee, more than twenty-five percent reported that the current legal climate has an adverse effect on training programs because it robs residents of the opportunity to exercise a level of responsibility appropriate to their stage of training.³⁸ Furthermore, excessive premiums make the recruitment of new faculty members more difficult.³⁹

The current medico-legal environment has eroded physician-patient trust and undermined the therapeutic value of the relationship between providers and patients. As Arnold S. Relman, Editor-in-Chief of the *New England Journal of Medicine*, stated at the committee's June 20, 1988, symposium: "Patients are likely to be seen as potential courtroom adversaries, thus straining the traditional bonds of beneficent concern and good will. If doctors are now more motivated to ensure careful, detailed workups of their patients, they are also often intimidated by the threat of litigation and as a result are more likely to do too much."⁴⁰ Once an adversarial element creeps into the interchange, the deterioration of the relationship perpetuates the potential for misunderstanding and anger, and sets the stage for a lawsuit. Moreover, the dissolution of the therapeutic alliance enhances the likelihood that a doctor will avoid high-risk patients.

According to both state and national surveys, there have also been some notable benefits from concern about professional liability. For example, ac-

35. See generally Banta & Thacker, *Assessing the Costs and Benefits of Electronic Fetal Monitoring*, 34 *OBSTET. GYNOL. SURV.* 627 (1979); *Policies Toward Medical Technology: The Case of Electronic Fetal Monitoring*, 69 *AM. J. PUB. HEALTH* 931 (1979).

36. See Nelson & Ellenberg, *The Asymptomatic Newborn and Risk of Cerebral Palsy*, 141 *AM. J. DIS. CHILD* 1333 (1987); Nelson & Ellenberg, *Antecedents of Cerebral Palsy: Multivariate Analysis of Risk*, 315 *NEW ENG. J. MED.* 81 (1986); Nelson & Ellenberg, *Obstetric Complications as Risk Factors for Cerebral Palsy or Seizure Disorders*, 251 *J. A.M.A.* 1943 (1984); Nelson & Ellenberg, *Apgar Scores as Predictors of Chronic Neurologic Disability*, 68 *PEDIATRICS* 36 (1981); Nelson & Ellenberg, *Neonatal Signs as Predictors of Cerebral Palsy*, 64 *PEDIATRICS* 225 (1979).

37. *INSTITUTE OF MEDICINE*, *supra* note 1, at 81-82.

38. *Id.* at 8.

39. *Id.* at 8.

40. *MEDICAL PROFESSIONAL LIABILITY*, *supra* note 2, at 102.

ording to a 1985 survey conducted by the American College of Obstetricians and Gynecologists, thirty-five percent of the obstetricians surveyed reported that they had changed the way they practiced obstetrics as a result of the risks of professional liability.⁴¹ Among the changes reported were the increased use of testing and other diagnostic and monitoring procedures, the increased use of written informed consent, more frequent consultations with other physicians, increased attempts to provide written or tape-recorded information to patients, and more frequent explanation of the potential risks of a recommended procedure.⁴²

Overall, the committee came to the conclusion that the tort system is "a slow and costly method of resolving obstetrical disputes and that it is contributing to the disruption of the delivery of obstetrical care in this nation."⁴³ Aside from limiting access, the threat of liability encourages the use of a variety of medically unnecessary procedures. Furthermore, both providers and patients have lost confidence in tort litigation as the best method of resolving claims of medical malpractice. Studies by Danzon, Lillard, and Sloan suggest that the tort reforms implemented since the 1970s have slowed the escalation in the frequency and magnitude of claims in some states.⁴⁴ However, the committee concluded that the reforms have not had a dramatic effect on the overall costs of the tort system, either directly or indirectly, in resolving claims of obstetrical malpractice.⁴⁵

Despite ample discussion of possible alternatives to the system of civil justice in resolving malpractice claims (such as arbitration, no-fault insurance with designated compensable events, and administrative law), the committee concluded that these alternatives have not been adequately tested in the United States.⁴⁶ Accordingly, there is insufficient data on the cost of these alternatives, the frequency of claims under them, or their effectiveness in resolving claims efficiently and fairly in the context of the American health care system.

41. AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, PROFESSIONAL LIABILITY INSURANCE AND ITS EFFECTS: REPORT OF A SURVEY OF ACOG'S MEMBERSHIP Table 28 (1985).

42. *Id.* at 22-23.

43. INSTITUTE OF MEDICINE, *supra* note 1, at 10.

44. P. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY (1985); P. DANZON, THE MEDICAL MALPRACTICE INSURANCE CRISIS REVISITED: CAUSES AND SOLUTIONS (1982); Sloan, *State Response to the Malpractice Insurance "Crisis" of the 1970's: An Empirical Assessment*, 9 J. HEALTH POL. LAW 629 (1985); Danzon & Lillard, *Settlement Out of Court: The Disposition of Medical Malpractice Claims*, 12 J. LEG. STUDIES 342 (1983).

45. INSTITUTE OF MEDICINE, *supra* note 1, at 10.

46. *Id.*

RECOMMENDATIONS

The committee made both long-term and short-term recommendations in an effort to resolve the problem of professional liability in obstetrics.

Long-term Recommendations

Alternatives to the Tort System

The committee recommends that states focus their reform efforts on developing alternative methods of resolving medical malpractice claims. Although there has been little practical experience with alternatives to the tort system, the committee determined that on the basis of the theoretical literature available, three alternatives appear particularly promising. The committee recommends that states evaluate these three proposals for limited implementation: The American Medical Association's fault-based administrative system,⁴⁷ the no-fault scheme of designated compensable events (including the variants enacted in Virginia and Florida that provide no-fault compensation for certain neurologically impaired infants),⁴⁸ and legislation authorizing the use of private contracts between providers and patients to govern professional liability.⁴⁹

Demonstration Projects Supported by the Federal Government

Although the committee believes that the primary responsibility for resolving the problem of professional liability rests with the states, it also believes that the federal government should stand ready to assist them. To that end, it recommends that the federal government authorize demonstration projects administered by the Department of Health and Human Services to finance pilot programs testing various solutions and studies of proposed state legislation.⁵⁰

National Data Base on Malpractice Claims

The federal government, through the Department of Health and Human Services, should assist in the development of a national malpractice claims data base to assist the states in understanding and solving the problem of professional liability. The Health Care Quality Improvement Act of 1986 required the establishment of data bank containing information about the licensing, sanctioning, and disciplining of health care providers.⁵¹ The com-

47. *Id.* at 137-38.

48. *Id.* at 136-37.

49. *Id.* at 139-41.

50. *Id.* at 154.

51. 42 U.S.C. § 11101 (Supp. V 1987).

mittee approves of this legislation, but believes that a more extensive data base is required to facilitate further study of the problem. It recommends that the national data base include compulsory disclosures by medical malpractice insurers of rates, payouts, settlements, and claims; by hospitals and other providers regarding claims; and by relevant state agencies.⁵²

Systematic Assessment of Technology

The committee has joined other government and non-government groups in recommending that sufficient primary data be generated to determine the safety, effectiveness, and other attributes of technological innovations and new clinical practices in obstetrics and other medical fields.⁵³ The committee's examination of electronic fetal monitoring and other changes in the practice of obstetrics led it to conclude that systematic effort is needed to establish the appropriateness, reliability, and effectiveness of new medical procedures before they are widely disseminated and become the accepted standard of care.⁵⁴

Short-Term Solutions

Problems of Access among the Poor

The committee believes that alternatives to the tort system hold the most promise, but also urges states to address immediately the disruptions and deterioration in maternity services for the poor that have been made worse by concern about professional liability.⁵⁵ The committee recommends that the states and the federal government contemplate several short-term solutions while they work toward resolving the professional liability crisis in general.⁵⁶ These solutions are described below.

Immunities Offered by the Tort Claims Act or Similar Coverage for Certain Obstetrical Providers

To solve the immediate problem posed by issues of professional liability in government-financed community and migrant health centers, Congress should either authorize the extension of the immunities offered by the Tort Claims Act or offer equivalent coverage to all providers of obstetrical care at these centers.⁵⁷ The committee recommends that medical personnel be cov-

52. INSTITUTE OF MEDICINE, *supra* note 1, at 154.

53. *Id.* at 155.

54. *Id.*

55. *Id.*

56. *Id.*

57. *Id.*

ered by the act only for activities related to obstetrical services.⁵⁸

State Contributions to Coverage for Medicaid Providers

As a temporary measure to ensure full access for women whose obstetrical care is financed partly by Medicaid, the committee recommends that states follow the examples of Missouri, Hawaii, and Montgomery County, Maryland, which have reduced the professional liability risk of the providers of obstetrical services to poor women.⁵⁹ Until the issue of professional liability in obstetrics is fully resolved, the committee recommends that states implement programs to indemnify or subsidize the liability-insurance premiums of providers of obstetrical services who participate in Medicaid or otherwise offer care to low-income women.⁶⁰

Expansion of the National Health Services Corps

The committee recommends a revival and expansion of the National Health Service Corps, whose resources have been severely restricted in recent years.⁶¹ "Congress should reinstate general scholarships, expand the program of scholarships for students with exceptional financial need, and increase loan repayment options to increase the number of physicians in underserved areas."⁶²

REFLECTIONS ON THE IMPORTANCE OF THE PHYSICIAN-PATIENT
RELATIONSHIP

Central to any discussion of the physician-patient relationship since the time of Greek philosophers is the importance of mutual trust. Both observation and clinical research confirm that a patient's confidence in his or her physician is central to the healing process. Indeed, research has demonstrated the importance of the placebo effect, that is, clinical benefits that are associated with medical therapy but are not ascribed to the therapy itself.⁶³ The placebo effect derives from the patient's confidence in the doctor and in the therapeutic process.

During the two years devoted to our examination of professional liability issues in obstetrics, we heard reports from physicians and observers that patient-physician trust has been eroded by the current professional liability climate. We became convinced that this erosion of trust is both one of the

58. *Id.*

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.*

63. R. BULGER, IN SEARCH OF THE MODERN HIPPOCRATES 121 (1987).

causes and one of the consequences of the medical professional liability crisis in obstetrics.

The most significant evidence documenting the breakdown in trust is indirect: if seventy percent of obstetricians in the United States can expect to be sued at one time or another,⁶⁴ it is abundantly clear that medical malpractice claims are not confined to the worst practitioners or the worst health care institutions, and that the traditional trust relationship is an anachronism.

There are many reasons why medical malpractice claims and litigation have proliferated. The United States is one of the most litigious societies in the world; no other nation relies so heavily on the courts for resolution of disputes. Moreover, couples in the United States who have given birth to a child with medical defects often have no financial recourse but a lawsuit against their health care providers. Societies with universal social insurance schemes, such as Canada and the United Kingdom, have been able to limit this problem. Patient expectations of the medical system are being constantly raised by the development of more sophisticated medical technologies. It is clear that the public must be educated to understand the limits of technology and to have a realistic understanding of what modern medicine can and cannot offer. Further, physicians are no longer regarded by the American public as virtually infallible. And, finally, many believe that increasing specialization and technology have led to the provision of care for higher risk patients who are more likely to experience a maloccurrence and more likely to sue.

The evidence of the professional liability crisis' effect on access to care and on delivery patterns indicates a breakdown in trust. This breakdown, combined with the attendant surge in medical malpractice litigation, is likely to cause the further deterioration of obstetrical care in the United States.

64. INSTITUTE OF MEDICINE, *supra* note 1, at 2.

