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The Malpractice Suit: Is it Needed?

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THE MALPRACTICE SUIT: IS IT NEEDED?

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A. INTRODUCTION

(1) *Basis For a Functional Analysis of the Malpractice Suit*

Should doctors in Ontario be granted immunity from liability for professional negligence? The malpractice suit against doctors has been said to have had negative effects on the practice of medicine, the tort system has been attacked as a totally inadequate system of compensation and the so-called "conspiracy of silence" among doctors is claimed to present victims of "medical accidents" with immense difficulties in prosecuting claims against members of the medical profession. It has therefore been suggested that a compensation scheme be established to provide compensation for all victims of medical accidents, regardless of fault, and that the malpractice suit be abolished.[1] In this paper we shall attempt to show that this problem is far more complex than it may seem at first and that simplistic solutions to the problem ignore important factors which merit attention. We shall analyse the various factors which deserve consideration and shall attempt to provide a theoretical framework for a balanced examination of the problem.

The medical malpractice suit is, of course, not the only tort action which has been subject to attack in recent years. Some attacks on tort law have been directed against tort law as a compensation system in specific spheres of activity, mainly in the road accident field;[2] others have been directed at tort

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[1]The first such suggestion seems to have been made by Ehrenzweig in *Compulsory "Hospital-Accident" Insurance: A Needed First Step Toward the Displacement of Liability for "Medical Malpractice"* (1964), 31 U. Chi. L. Rev. 279. As the title of the above article suggests, Ehrenzweig did not advocate abolishing all suits for medical malpractice but limited his treatment to the area of the vicarious liability of hospitals. For proposals that all medical malpractice suits be abolished and replaced by insurance schemes see Harry H. Root, III, *Medical Malpractice Litigation: Some Suggested Improvements and a Possible Alternative* (1966), 18 U. Fla. L. Rev. 623 and Haines, *The Medical Profession and the Adversary Process* (1973), 11 Osgoode Hall Law Journal 41. For a proposal to institute an insurance scheme alongside the tort system see Morris, *Malpractice Crisis—A View of Malpractice in the 1970's* (1971), 38 Ins. Counsel J. 521.

[2]The books and articles dealing specifically with road accident compensation schemes to replace or supplement the tort action are by now far too numerous to list here. But see Keeton and O'Connell, *Basic Protection for the Traffic Victim* (Boston: Little, Brown & Company, 1965) and the bibliography in Gregory and Kalven, *Cases and Materials on Torts* (2d ed. Boston: Little, Brown & Company, 1969) at lix-lxii. For a review of many proposals in this field see Prosser and Wade, *Cases and Materials on Torts* (5th ed. Mineola, New York: Foundation Press, 1971) at 631-45.

law in general, and a rather impressive case has been made out for abolishing the tort suit in respect to personal injury entirely.[3] Although some of the arguments which have been advanced to show the inadequacy of the law of torts as a system for allocation of losses in the technological society of today hold true when dealing with the "usual" type of personal injury tort suit, it seems to us that care must be taken not to over-generalize. In examining whether the medical malpractice suit should be abolished and replaced by some other system of compensation, it is essential to attempt an evaluation of the functions that the malpractice suit fulfils within a given society. While the theoretical basis for liability in torts may be common to all negligence suits whether they be malpractice suits, road accident suits, or industrial injury tort suits, it is quite possible that the law of torts fulfils different functions in each area of activity. For example, a functional analysis of the road accident suit and the malpractice suit may lead us to the conclusion that the one should be abolished and the other retained (with or without certain reforms).

Before proceeding, it may be worthwhile to clarify a few terms which shall be used in our discussion.

Social scientists are wont to speak of the "functions" and "disfunctions" of social institutions. In this context the term "function" is taken to mean the helpfully relevant objective consequences of the institution to the social system being analyzed;[4] "disfunctions" are the harmfully relevant objective consequences of the institution to the system.[5] Another basic distinction made is the distinction between "manifest functions" (or disfunctions) and "latent functions" (or disfunctions).[6] "Manifest functions" are those objective consequences which are intended and recognized by participants in the system,[7] while "latent functions" are those objective consequences which are neither intended nor recognized.[8] The social scientist takes it as axiomatic that in social engineering care must be taken to observe both the manifest as well as the latent functions and disfunctions of any institution which is the object of the engineering. As the original proponent of the distinction between manifest and latent functions has written:

> To seek social change, without due recognition of the manifest and latent functions performed by the social organization undergoing change, is to indulge in social ritual rather than social engineering.[9]

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[3]See Atiyah, *Accidents, Compensation and the Law* (London: Weidenfeld & Nicolson, 1970); Ison, *The Forensic Lottery* (London: Staples Press, 1967); Franklin, *Replacing the Negligence Lottery: Compensation and Selective Reimbursement* (1967), 53 Va. L. Rev. 774; *Report of the New Zealand Royal Commission on Compensation for Personal Injury* (1967).

[4]See Bredemeier and Stephenson, *The Analysis of Social Systems* (New York: Holt, Rinehart & Winston, 1962) at 41.

[5]*Id.*

[6]*Id.*, at 45-46.

[7]*Id.*

[8]*Id.*

[9]See Robert K. Merton, *Social Theory and Social Structure* (Revised and enlarged ed. New York: Free Press, 1957) at 81.

The advocate of law reform seeks reform as a means of social change, and he too must give due recognition both to the manifest and the latent functions performed by the institution which he seeks to reform. Such recognition will help him to evaluate not only whether reform is needed or not, but also what form the reform should take.

To return to doctors' professional liability for negligence: within the system of relationships between the medical profession and the wider community of which it forms a part, the malpractice suit performs various functions, some manifest and others latent.[10] The most obvious manifest function of the malpractice suit is to provide a means of compensating those members of the community who suffer loss as a result of the professional negligence of a doctor. It would not be difficult to devise an alternative mechanism which could fulfil this function. However, the malpractice suit also serves to regulate certain medical practices, and it may provide a vehicle for exerting social control over the medical profession. Care should be taken to analyze and assess any such functions before advocating reform. The malpractice suit may also have latent disfunctions (i.e. it may have harmful consequences to the system of relationships between the medical profession and the rest of society). After weighing functions against disfunctions, we may reach the conclusion that the functions of the malpractice suit are so outweighed by the disfunctions that they should be ignored. We may also be able to devise an alternative mechanism which would fulfil both the manifest and latent functions of the malpractice suit, but not the disfunctions.

In advocating law reform there is another factor which must be taken into account. We must examine what the institution under review does not do, i.e. that which is neither a manifest nor a latent function of the institution, though we would favour an institution which fulfilled such a function. To illustrate this point, let us examine the criticisms that have been levelled against the tort action in road accident cases. One of the basic arguments has been directed at what the tort action does not do—it does not provide compensation for all victims of road accidents, regardless of fault.[11] The classic reply to this charge has been that the negligence action is not designed to compensate all accidental losses—this is not its manifest function (i.e. it is neither the intended nor recognized consequence of the negligence action). The counter-argument is that this is one of the reasons we wish to abandon

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[10] It will be clear from our analysis that we have not attempted to classify which functions of doctor's professional liability are manifest and which are latent. We have adopted "functional" terms in our analysis because the point we wish to make in the present discussion is that whether one regards the only aim of modern tort law to be the allocation of losses or holds that tort law has varied aims, when advocating the abolition of an existing legal institution one must consider what the objective consequences of that institution's existence are. Some of these consequences (the manifest functions) are intended and recognized. Others (the latent functions) are not intended and, as Professor Linden has put it, "may even be vehemently denied". (See Linden, *Canadian Negligence Law* (Toronto: Butterworths, 1972) at 469.) We have referred to the distinction between manifest functions and latent functions so as to emphasize that all the consequences of liability for malpractice must receive our consideration whether they are intended and recognized or not.

[11] See Keeton, *Compensation Systems—The Search for a Viable Alternative To Negligence Law* (St. Paul, Minnesota: West Publishing Co., 1969) at 1.

the tort suit in road accident cases—we want a system which will perform a function which the tort system does not perform.

(2) *Common Generalizations to be Avoided*

We have cautioned against the tendency to over-generalize.

Generalization in this respect may take on many forms:

1. *Generalizations As Regards Tort Law in General*

The tort suit may fulfil different functions in different spheres of activity. There are many factors which distinguish the tort action against a negligent driver from the action against a negligent physician, though both are based on the tort of negligence.[12] A few of these factors should be mentioned here:

First, the doctor is a member of a profession—a definite community within the larger society:[13] drivers, per se, do not constitute a community. We shall return to the implications of this factor later. Secondly, in North America most families own cars.[14] Thus, a large proportion of the adult community are not only potential victims of road accidents—they are also potential defendants. Thirdly, driving is an area which has become highly regulated by law, and many accidents due to negligence involve some form of breach of a traffic regulation. The practice of medicine is highly dynamic and demands that the professional enjoy a high degree of discretion. It cannot be subjected to the same degree of regulation as driving. Furthermore, to the extent that it is regulated, it is largely self-regulated by the profession. It has been argued that negligence in driving endangers the driver's own life and that this provides the strongest possible incentive not to drive negligently.[15] The risk of being sued if negligent can provide no further incentive for safe driving. This argument does not apply to the negligent practice of medicine. Finally, though both the negligent driver and the negligent doctor will generally carry liability insurance and will not face the financial burden of an adverse verdict, such a finding against a doctor may have repercussions on the doctor's professional reputation.[16]

In the light of these distinguishing factors,[17] we are somewhat wary of generalizations, such as the statement that tort law has no deterrent effect. While it may be true that tort law plays no part in deterring negligent driving this does not mean that tort law plays no part in deterring negligent practices of employers, bankers and physicians. Each case must be examined separately in order to ascertain if and to what extent tort law deters.

2. *Generalizations From One Society to Another*

Given the common theoretical foundation of malpractice suits in common law jurisdictions, there is a tendency to assume that the malpractice suit fulfils the same functions in all jurisdictions. This is not the case, and it is important to appreciate that the arguments which have been directed against malpractice actions in the United States may on examination prove inapplicable in Canada, England, or any other common-law country.

There can be no doubt that the upsurge in the number of malpractice suits against doctors in recent years has created a major social problem in

many American states.[18] It may be that a position has been reached in which the disfunctions of the malpractice suit outweigh the positive functions, and that a very strong case can be made out for it to be abolished (or restricted). In Canada, although the number of malpractice suits has risen over the last few years,[19] even the greatest critics of the malpractice suit can hardly claim that a national crisis is imminent.

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[12]We shall constantly allude to the analogy between the malpractice suit and the road accident suit because it seems that much of the thinking in negligence law policy today has been largely influenced by the voluminous material on the negligent action in road accident cases. This analogy has also often been made by those arguing for abolishing or restricting the malpractice suit. See, for example, the essay by Crawford Morris in *Medical Malpractice: The Patient Versus the Physician,* a study submitted by the Subcommittee on Executive Reorganization to the Committee on Government Operations of the U.S. Senate (1969), 435 at 462 (hereinafter this study shall be referred to as the *U.S. Senate Malpractice Study);* Ehrenzweig, *supra,* note 1 at 279-80.

[13]Goode, *Community Within a Community: The Professions* (1957), 22 Am. Soc. Rev. 194.

[14]See the figures in Prosser and Wade, *supra,* note 2 at 620.

[15] Keeton, *supra,* note 11 at 44.

[16]Fleming, *Developments in the English Law of Medical Liability* (1959), 12 Vand. L.R. 633 at 634.

[17]We have not attempted a full analysis of all the factors distinguishing the malpractice suit from the road accident suit but have merely chosen the more obvious factors to illustrate the point that, given the peculiar nature of the malpractice suit, generalizations are not warranted. Another important aspect of the malpractice suit (as opposed to the road accident suit) is that the action derives from a prior relationship (possibly but not necessarily contractual) between the plaintiff and defendant. For a theory based on this aspect of the malpractice suit see Miller, *Cases of Uncertain or Unknown Causation and Negligence: Relationship Analysis as a Real Alternative to Present Inadequate Concept* (1968), 16 Kan. L.R. 209. Also see Sherman, *The Standard of Care in Malpractice Cases* (1966), 4 Osgoode Hall Law Journal 222 at 241.

[18]It is difficult to obtain reliable statistics on the increase in malpractice claims. However, the United States Senate Subcommittee which studied the problem reached the definite conclusion that the number of malpractice suits was rising sharply in certain regions of the United States and that malpractice litigation "threatens to become a national crisis": See *U.S. Senate Malpractice Study, supra,* note 12 at 1. In his National Health Message in February, 1971, President Nixon directed that a commission on medical malpractice be established by the Secretary of the Health, Education and Welfare Department: (1972), 39 Insurance Counsel J. 22.

[19]Until 1969 about 65 writs were issued against members of the Canadian Medical Protective Association each year. In 1970 this number rose to 80 and in 1971 to 131. However, in the above years the membership of the Association rose from 18,000 to 24,000. The experience of the Association shows that in slightly less than half the cases where writs have been served the disputes progress to the judgment stage or the necessity for a settlement: *Seventy-First Annual Report of the Canadian Medical Protective Association,* June 1972, at 14. According to the above figures in 1971 one suit was brought for every 183 doctors insured. We have no similar figures for the whole of the United States. However, in an article on the professional liability rate increase in the Los Angeles area in 1969, the President of an insurance company specializing in medical liability insurance claimed that his company expected one claim for every 10 doctors insured during one year. See *United States Senate Malpractice Study, supra,* note 12 at 1044. The difference between the extent of malpractice litigation in the United States and Canada can also be gauged by comparing the cost of medical liability insurance: see notes 38-40 *infra.*

There are numerous factors which explain the difference in the volume of malpractice litigation in the two countries and which make it unlikely that Canada will move in the direction of the United States.[20] For example, the contingent fee is the rule in the United States in personal injury cases.[21] In Ontario it is illegal.[22] In the United States, malpractice cases are tried by juries.[23] In Ontario they are heard by a judge without a jury.[24]

3. *Generalizations Regarding the Effect of a Malpractice Action on the Practice of the Defendant Doctor*

While it may appear obvious to many that an adverse finding against

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[20]See *Report of the Ontario Committee on the Healing Arts,* (1970), Volume 3 at 71. The Committee mentioned two factors which distinguished the United States and Canadian situations which we have not mentioned here: a) greater readiness in the United States to rely on the "res ipsa loquitor" rule and b) the role played by the Canadian Medical Protective Association as opposed to American liability insurance carriers. The difference between the American and Canadian medical malpractice scene has not gone unnoticed in the United States and some in that country find it tempting to ask "Why can't it be like that here?": See Uhthoff, *Medical Malpractice—the Insurance Scene* (1969), 43 St. Johns L. Rev. 578 at 599.

[21]American Physicians claim that the contingent fee system has had a major impact on the incidence of malpractice claims. See *Law and Medicine* "Medical Liability", prepared by the AMA Law Division and annexed to the *U.S. Senate Malpractice Study, supra,* note 12 at 999. Also see, Martin, *Malpractice Crisis: The View of the Defense Trial Bar* (1971), 38 Insurance Counsel J. 539.

[22]Section 30, *The Solicitors Act,* R.S.O. 1970, c. 441. Also see Williston, *The Contingent Fee in Canada* (1968), 6 Alberta L. Rev. 184 at 190.

[23]The sympathy of civil juries with victims (especially if their injuries are serious) was discussed in a 1969 California television programme on "Medical Malpractice" the text of which is annexed to the *U.S. Senate Malpractice Study, supra,* note 12 at 420.

[24]The Ontario Attorney-General's Committee on Medical Evidence considered trial by judge instead of jury to be a real safeguard for the medical profession against the danger that the malpractice suit would operate so as to prejudice the profession and their patients: *Report of the Attorney General's Committee on Medical Evidence in Court in Civil Cases* (1965) at 82.

A perusal of the reported Canadian decisions in malpractice actions tends to show that not only are the decisions unaffected by a feeling of sympathy with the patient—the courts seem on occasion to exact a somewhat stricter burden of proof in malpractice actions than the burden of proof in, for example, actions by road accident victims and seem to be somewhat eager to protect the doctors against findings which the courts think may impugn their professional standing: See, e.g., a) *Gent and Gent* v. *Wilson,* [1956] O.R. 257, where the court said (at 266):

> "It is trite to say that it is always easy to be wise after an event, and in cases of this kind care must be taken not to condemn as negligence what may be, and in this case undoubtedly is, only a misadventure. *Nothing is to be imputed to the defendant that is not clearly proved against him.*" (our emphasis).

What has happened to the "balance of probabilities" which is the accepted burden of proof in civil cases? b) *Moore* v. *Large,* [1932] 46 B.C.L.R. 179 where the court decided "that the appellant should be acquitted of the charge of negligence" and ended the judgment by stating (at 194):

> "Dr. Large I have no doubt, is, as was testified, a skilful and capable physician of long experience and the evidence does not warrant a finding that would impair a reputation obtained by years of devotion to professional work."

Once again the court regards the case as a "charge of negligence" and seems to return a verdict of "not guilty" instead of adjudicating a case between two litigants and deciding the outcome on the "balance of probabilities".

an individual doctor in a malpractice case will have a detrimental effect on the doctor's practice, it is by no means clear that this is indeed the case.

To the best of our knowledge no study has been done in Canada to determine what effect, if any, malpractice suits have on defendant doctors' practices. In the United States an attempt was made to answer this very question, and the results were rather surprising.[25] Not only did the study show that a malpractice suit had no adverse effect on a doctor's practice (whether he won or lost the suit). In some cases the defendant doctor's practice improved as the result of a malpractice suit.[26] This somewhat unlikely result was ascribed to the fact that the colleagues of defendant doctors sympathized with the plight of these doctors and began referring patients to them, though they had not done so before the suit.

While we do not know whether a similar inquiry in Canada would yield the same results, we do know that without such an empirical inquiry we can have no idea what the effect of the malpractice suit on the defendant's practice really is.

B. "TO BE OR NOT TO BE"

(1) *Arguments in Favour of the Abolition of the Malpractice Action*

(a) *Accent on Doctors—Not Victims*

We shall now review the arguments which have been advanced in favour of the abolition of the malpractice action against doctors. Once again it is revealing to compare the arguments here to those which have been put forward in support of the abolition of the tort action in cases of injuries resulting from road accidents, and in support of its replacement by a compensation scheme of one sort or another. There is a basic difference in approach in these two spheres of activity; whereas the accent in dealing with road accidents is on the *victims,* in the medical malpractice field, the accent is on the defendant doctors. The main impetus behind the numerous proposals for road accident compensation schemes has been to provide some kind of compensation for all victims of road accidents; not merely for those who have a case in torts. Tort law has been attacked as an expensive and rather protracted method of providing compensation for some victims of road accidents. What is needed is a cheaper and more efficient scheme of making compensation available to all such victims. Nobody has claimed that potential liability of drivers has had an *adverse* effect on their driving—the argument has been that it has *no effect.* On the other hand, it has been argued that the malpractice suit has an adverse effect on the practice of medicine. To put it in the terms we have used above: the tort action in the road accident field fails to perform a vital function; the malpractice action has a disfunction.

(b) *Arguments Voiced in the United States—Do They Apply in Canada?*

In the United States it has been strongly argued that the tremendous upsurge in medical malpractice cases has had disastrous effects on the prac-

[25] See Schwartz and Skolnick, *Two Studies of Legal Stigma* (1962), 10 Social Problems 133.

[26] *Id.,* at 138.

tice of medicine. These effects (or disfunctions) of the malpractice suit may be described as follows:

i) *Practice of Defensive Medicine:* Certain types of treatment or diagnostic procedures are known to be "suit-prone". Though the considered opinion of the medical profession might be that these types of treatment or procedures are advisable in certain circumstances, fear of a malpractice suit leads doctors to refrain from administering them. The patient who might have benefitted from the treatment or diagnosis is the loser.[27]

This line of argument was developed in an essay submitted by Crawford Morris to the United States Senate Subcommittee on Executive Reorganization which, at the time, was engaged in an examination of the problem of medical malpractice.[28] Examples are given in this essay of delicate diagnostic procedures which are known to involve not inconsiderable risk, and operative techniques which have their known hazards.[29] Lawsuits against doctors who have used these procedures or techniques are said to have made doctors reluctant to use them despite their potential benefits. However, it is not at all clear to this writer that the reluctance of doctors in this regard is necessarily undesirable.[30] Even if the dangers inherent in such procedures and techniques are very slight (and affect 0.2% of the patients involved)[31] this is unlikely to be of much comfort to those few patients affected. Crawford Morris argues that doctors should weigh the benefit-to-risk ratio before undertaking any of the more risky techniques or procedures.[32] The danger of a malpractice suit need not necessarily force doctors to abstain from risky procedures and techniques. Doctors may, however, be forced to take greater heed of the benefit-to-risk ratio and to make sure that the patient (or his family) is fully aware of the risks involved. If the patient has granted informed consent to the treatment, absent any lack of skill by the doctor administering the test, a malpractice suit would appear to have little chance of succeeding.[33] Problems seem to have arisen in the United States in the

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[27]See *U.S. Senate Malpractice Study, supra,* note 12 at 7; Wachowski and Stronach, *The Radiologist and Professional Medical Liability* (1957), 30 Temple L. Q. 398; Statement of Dr. Arthur J. Mannix Jr. to N.Y. State Senate Committee on Health (1971), 38 Insurance Counsel J. 208.

[28]See response to the Subcommittee prepared by Crawford Morris, *U.S. Senate Malpractice Study, supra,* note 12, 435 at 453 ff.

[29]*Id.,* at 454-55. Cf. 2 Louisell and Williams, *Medical Malpractice* (Albany: M. Bender, 1969) at 568-82. These authors distinguish between the hazards and excesses of modern medicine.

[30]The positive aspects of the effect of increased malpractice litigation have not been ignored by the whole American medical profession: See *U.S. Senate Malpractice Study, supra,* note 12 at 222. (Quotation from an editorial in the New England Journal of Medicine).

[31]This is the proportion of people generally thought to be adversely affected by the translumbar aortogram. See *U.S. Senate Malpractice Study, supra,* note 12 at 454.

[32]*Id.,* at 455.

[33]As we have seen, in Canada, at least, there are enough protective devices to discourage a person from bringing a malpractice action unless he has a fairly good chance of success.

cases quoted in the essay because the doctor has not fully informed the patient of the risk involved.[34]

ii) *Unnecessary Diagnostic Tests:* The physician should not advise the patient to undergo diagnostic tests (such as blood tests or x-rays) unless he cannot reasonably establish the necessary information without them.[35] Malpractice suits against doctors in which the plaintiff has claimed that a correct diagnosis would have been reached had the defendant doctor advised diagnostic tests or procedures have led doctors to advise such tests as a matter of course even when they are not strictly necessary for the protection of the patient. This has resulted in considerable expense and some risk to their patients.[36]

It is beyond the scope of this paper to determine whether the above two claims relating to the disfunctions of malpractice suits in the United States have been substantiated or not.[37] The point we wish to make is that in Canada there is no evidence to show that malpractice suits have the above disfunctions. For the reasons stated above, it is our opinion that there is no justification for making any generalizations. If the argument is that personal professional liability of doctors in Canada is having an adverse effect on the practice of medicine some evidence of the Canadian situation must be brought to substantiate this argument.

iii) *Rising Costs of Liability Insurance Cause Increase in Medical Fees:*

In the United States the frequency of medical malpractice suits and the amount of the awards against doctors have led to sharp increases in the cost of doctors' liability insurance.[38] Some insurers have left the field of medical liability insurance altogether, and doctors with records of many malpractice suits may be unable to find an insurer willing to underwrite them.[39] The increase in the cost of liability insurance is passed on to the patients in the form of increased fees thus raising the cost of medical attention.

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[34]See *U.S. Senate Malpractice Study, supra,* note 12 at 458.

[35]The Code of Ethics approved by the General Council of the Canadian Medical Association in June, 1970 states that an ethical physician "will recommend only those diagnostic procedures which he believes necessary to assist him in the care of his patient, and therapy which he believes necessary for the well-being of the patient".

[36]See *U.S. Senate Malpractice Study, supra,* note 12 at 22 (letter of Eli P. Bernzweig, of the U.S. Department of Health, Education and Welfare to Senate Subcommittee), at 457 (essay by Crawford Morris); Bernzweig, *The Malpractice Crisis: A Government Expert's View* (1972), Insurance Counsel J. 24.

[37]It is interesting to note that in the response of the American Medical Association to the U.S. Senate Subcommittee, which was investigating the problem of malpractice, the Director of the Association's Legal Research Department claimed that there is no solid evidence that malpractice litigation has had the adverse effects in medical practice which we have described and that it would be virtually impossible to prove whether such effects actually occur: *U.S. Senate Malpractice Study, supra,* note 12 at 510.

[38]See *U.S. Senate Malpractice Study, supra,* note 12 at 9 (report of Subcommittee Chairman) and at 1041 (response from The Nettleship Company of Los Angeles, California, an insurance company specializing in medical liability insurance); Uhthoff, *supra,* note 20; Linster, *Malpractice Crisis: Insurance View of Malpractice* (1971), 38 Insurance Counsel J. 528 at 529; Daughtry, *Malpractice Crisis: The View of the Medical Profession* (1971), 38 Insurance Counsel J. 534.

[39]*U.S. Senate Malpractice Study, supra,* note 12 at 465; Uhthoff, *supra,* note 20 at 578; Morris, *supra,* note 1 at 521.

This clearly illustrates that the medical malpractice suit has a latent disfunction in the United States which it does not have in Canada. The annual cost at present of medical protection with the Canadian Medical Protective Association is thirty-five dollars.[40]

(c) *Malpractice Liability and the Adversary Process*

It is argued that the adversary system is not suited to adjudicating disputes involving the medical profession.[41] Mr. Justice Haines has shown convincingly that the adversary process leaves a great deal to be desired and that serious thought should be given to possible reforms of the system.[42] However, we submit that there is no justification for singling out the medical profession and granting doctors immunity from professional liability so as to avoid their having to resolve their disputes with laymen in an adversary trial.[43] Although doctors may not take kindly to the adversary process, this would seem to be equally true of engineers, manufacturers, civil servants and any other classes of potential defendants in tort actions.

Even if we agree that in the case of doctors there are special considerations in favour of abandoning the adversary process, it does not follow that doctors should be granted immunity from professional liability. In the United States attempts have been made to resolve malpractice disputes before arbitration boards consisting of doctors and lawyers.[44] Many of the less desirable aspects of the adversary process might be eliminated in proceedings before such boards.

(d) *Malpractice Suit Inadequate as Compensation System*

The malpractice suit has come under fire as a mechanism for compensating victims of "medical accidents".[45] In this respect the arguments which have been levelled against the tort action as the basic compensation system for road accident victims would seem to apply to malpractice suits as well. In many ways malpractice suits are even more deficient than other tort suits. They are notoriously expensive and some of the difficulties in obtaining witnesses to prove fault are peculiar to the malpractice suit. Whereas the vast

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[40] See *Seventy-First Annual Report of the Canadian Medical Protective Association*, June 1972, at 24.

[41] See Haines, *supra*, note 1.

[42] *Id.*

[43] Mr. Justice Haines argues in his article (see note 1, *supra*) that the adversary process is foreign to the way doctors usually resolve their problems. This could be said about many other classes of people who may be forced to defend themselves in the adversary system. Furthermore, doctors do not rely exclusively on the scientific as opposed to the adversary method. The adversary method is often used by doctors in evaluating scientific publications: See Polsky, *The Malpractice Dilemma: A Cure for Frustration* (1957), 30 Temple L.Q. 359 at 363. Cf. Powers, "Interprofessional Education and Medicolegal Conflict as Seen from the Other Side", (1965), in Curran and Shapiro, *Law, Medicine and Forensic Science* (Boston: Little, Brown & Company, 1970) 3 at 8.

[44] For a description of some such schemes at work see *U.S. Senate Malpractice Study, supra*, note 12 at 479-80. Also see Morris, *supra*, note 1 at 524-26.

[45] See Ehrenzweig, *supra*, note 1.

majority of claims arising from road accidents are settled out of court,[46] in Canada, relatively few malpractice claims are settled.[47] For a variety of reasons many victims of medical accidents go without compensation.

Despite its manifest shortcomings, it does not necessarily follow that the malpractice suit should be abolished entirely. We would definitely favour reform of the present system so as to make some compensation available to all victims of medical accidents without their having to bring a tort action. However, we submit that the question of whether the malpractice suit should be retained or not, should not depend entirely on whether it is the simplest system of compensation, but rather on whether it fulfills other functions which are important enough to merit its retention alongside a suitable compensation scheme. We shall return to the question of compensation, but before doing so, it may be instructive to consider the other functions of the malpractice suit.

(2) *The Functions of the Malpractice Suit*

(a) *Social Control Over the Medical Profession*

In order to appreciate fully the vast difference between the medical malpractice suit and most other types of negligence actions in respect of personal injuries, it is essential to look at the medical profession of which the defendant doctor is a member. As opposed to the defendant driver, for example, the defendant doctor is part of a defined community within the larger society. The professions have been called a "community within a community".[48]

The layman brings his problem to the professional because he has neither the knowledge nor the skill to solve it himself.[49] He is usually unable to evaluate the competence of the professional and often must place his faith in the professional as such.[50] The fact that a profession has a monopoly over knowledge and skills which are important to the rest of society places a great deal of power in the hands of the profession and gives it the potential to exploit

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[46]See *Report of the Osgoode Hall Study on Compensation for Victims of Automobile Accidents* (1965), Chap. IX, at 7. Ison's study of the position in Britain revealed that of the *successful* road accident cases reported by plaintiff's solicitors, 76% were settled without commencement of proceedings, 9% after commencement of pleadings, but before close of pleadings, 11% after close of pleadings but before trial and 1% during the trial. Only in 3% of the successful cases was judgment given: Ison, *supra,* note 3 at 151. Also see Atiyah, *supra,* note 3 at 281-84.

[47]According to the statistics published by the Canadian Medical Protective Association, the number of writs served against members of the Association in the years 1967-1971 were as follows: 1967-64, 1968-65, 1969-62, 1970-80, 1971-131. The number of actions settled in the same years were: 1967-17, 1968-20, 1969-15, 1970-21, 1971-22. In other words, whereas in the years 1967-70 (inclusive) an average of 68 writs a year were served against doctors only 18 claims a year were settled: See *Seventieth Annual Report of the Canadian Medical Protective Association,* June 1971, at 21 and *Seventy-First Annual Report of the Canadian Medical Protective Association,* June 1972, at 29.

[48]See Goode, *supra,* note 13. Cf. Bucher and Strauss, *Professions in Process* (1961), 66 Am. J. of Soc. 66.

[49]Goode, *supra,* note 13 at 196.

[50]*Id.*

society.[51] "It might use its monopoly to enrich itself or enlarge its power rather than in the best interests of its clients".[52]

In the face of such potential power, there must be some form of socialization of entrants to each profession to ensure that they will accept the tradition that the professions have built up not to over-exploit their potential power.[53] Some form of social control over the professions must also be exerted by the larger community.[54] This is important not only in order to prevent exploitation of society by the professions — it is important in order to give the individual layman trust in the professional to whom he must turn for help. Were the individual to believe that the professional was seeking to exploit him, he would not trust him as far as he does.[55] This aspect of social control over the professions is especially important in the medical profession where the trust of the patient in the doctor treating him may be an important factor in the success of the treatment.

The law is only one mechanism for exerting social control over the medical profession, and while it is possibly not the most important mechanism, its function in this respect can hardly be ignored. It is submitted that a tort system which enables the individual to force the medical profession to account for its practices in open court is a valuable link in the chain of legal control over the profession.[56]

Let us indulge in some speculation about the role the tort suit may have to fulfil in controlling the medical profession in the future. Medical science is developing rapidly, and few of us would deny that progress in medical science is beneficial to society and should be suitably encouraged. However, encouragement of medical progress is only one of the values accepted in society and, when it comes into conflict with other values, we must have a means of weighing the conflicting values in order to resolve the conflict in a balanced fashion. Those deeply involved in the furthering of medical science may in their enthusiasm tend to ignore other values which, when fully considered, may be reckoned as important, if not more important, than medical progress. The problem of experimentation with human beings presents an excellent illustration of the type of problem where such a conflict of values is likely to arise.[57] The tort action provides a framework for resolving this type of conflict and preventing one group from imposing its values on the larger community.[58]

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[51] *Id.* Also see Becker, "The Nature of a Profession" in Katz, *Experimentation with Human Beings* (New York: Russell Sage Foundation, 1972) at 186; Olsen, *The Logic of Collective Action* (New York: Schocken Books, 1968) at 137-41.

[52] Becker, *supra*, note 51 at 186.

[53] Goode, *supra*, note 13 at 194.

[54] *Id.*

[55] *Id.*, at 196.

[56] For a discussion of this function of negligence law in general—and not as related only to the medical profession, see Linden, *supra*, note 10 at 493 ff.

[57] For an example of just such a conflict see the case of *Hyman* v. *Jewish Chronic Disease Hospital* in Katz, *supra*, note 51 at 9-65.

[58] For an important Canadian illustration of the problem presented by over-enthusiastic medical research men see *Halushka* v. *University of Saskatchewan* (1966), 53 D.L.R. (2d) 436.

(b) *Quality Control*

(i) *Judicial Review and Change in Medical Practices*

The tort suit provides an avenue for judicial review of certain practices of the medical profession. Practices of the profession are subject to challenge and may have to be defended in court. This may lead to changes in medical practice. In *Anderson* v. *Chasney*[59] a sponge had been left in a child's nose during an operation, and the child died as a result. The doctor's defence to the action was that he had searched in the child's nose before terminating the operation and had not detected a sponge. Evidence was brought to show that the practice in the medical profession was not to carry out sponge counts in such operations. The action was successful, and the court held that failure to see to it that a sponge count was held was negligence on the part of the doctor. This decision did not go unheeded by the medical profession. The decision of the trial court was reported in the Canadian Medical Association Journal,[60] and when the decision was affirmed in the Supreme Court of Canada, a comment was published in the same journal.[61] About a year later, another tort action was brought by a woman in whose body a sponge had been left during an operation. The case was settled out of court.[62] Nevertheless the circumstances of the case were brought to the attention of the medical profession who were advised that:

> Circumstances such as this should remind surgeons of two or three important things. It should be routine at every operation in every hospital for a sponge count to be done. If the procedure is not routine surgeons should remember that, as the responsibility for error in the absence of a count will rest on their shoulders, they have the right and the power to demand that at least at their operations a sponge count shall be done, a permanent record of it shall be made and be kept where it will be available in the future.[63]

The above development provides a good illustration of the point we are making. The manifest function of the tort action in the above cases was to provide compensation for the victim of the doctors' negligence. However, the tort action also led to a change in the practices of the medical profession.[64]

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[59] [1949] 4 D.L.R. 71; affirmed [1950] 4 D.L.R. 223.

[60] (1948), 58 Can. Med. Assoc. J. 577.

[61] (1950), 63 Can. Med. Assoc. J. 405.

[62] (1951), 64 Can. Med. Assoc. J. 165.

[63] *Id.*, at 166.

[64] This positive function of the malpractice action has been recognized even by those in the United States who are most critical of the way malpractice litigation has developed in that country. Thus, in his essay, submitted to the U.S. Senate Subcommittee, Crawford Morris wrote: "There are a few instances, I concede, where malpractice litigation has brought to light deficiencies in procedures or better ways to do things which probably would have gone unnoticed but for such litigation. In these few instances I must concede that malpractice litigation (but not the threat thereof) has improved to such extent the quality of patient care". To illustrate this point Mr. Morris quotes the thalidomide litigation which exposed the hazards of improper animal research and reporting and casual clinical research by unqualified medical "researchers" thus leading to a tightening up of clinical research protocols and "surgical" litigation which in turn led to the ultimate reformation of package inserts to include warnings against use in laminectomy procedures: *U.S. Senate Malpractice Study, supra,* note 12 at 463.

It should be noted that a tort suit against a doctor can have an impact even if it is settled out of court. Most Canadian doctors are members of the Canadian Medical Protective Association.[65] This Association publishes an annual report which brings to the attention of its members those cases which have been dealt with by the Association during the year and are thought to be of special interest to the profession.[66] Thus, to quote but a few examples, doctors have been warned — of the risks of angiography and "that arteriography by the oscillary route is so dangerous that it ought seldom to be used":[67] that at the end of an operation a careful, deliberate search, manual and visual for retained instruments and sponges should be an integral part of any operative procedure,[68] and that Tramcinolone Acetonide may produce local atrophy at the site of injection, and it should therefore be used with caution.[69]

A tort suit against a doctor may bring certain deficiencies in medical practice to light. If this does not cause the medical profession to change its practices, it will at least make doctors more aware of the dangers involved in certain types of treatment or procedure. This is an important function of the malpractice suit. Only an empirical study could tell us to what degree the function tort law fulfils in this respect leads to a reduction in the number or severity of medical accidents. However, it is clear that this function of the malpractice suit cannot be ignored.

(ii) *The Deterrent Effect of the Malpractice Suit*

Does the possibility of a malpractice suit deter negligent conduct by doctors? We have hinted that there are cogent reasons for speculating that even if the tort suit does not act as a deterrent in other spheres of activity, in the sphere of professional liability it has some deterrent effect. In order to go beyond the stage of speculation an empirical study would be necessary.

We should, however, note that there are members of the medical profession who believe that the malpractice suit deters negligent practices and helps to encourage a higher standard of care by doctors.[70] Medical journals contain

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[65] In 1966 there were 23,353 physicians in Canada (see *Report of the Committee on the Healing Arts*, Vol. 2 at 56). In the same year the Canadian Medical Protective Association had 17,275 members (see *Sixty-Ninth Annual Report of the Canadian Medical Protective Association*, June, 1970, at 24). By 1971 the membership of the Association had risen to nearly 24,000 (see *supra*, note 19) whereas in December, 1970 the number of active civilian physicians in Canada was 31,166 (see 1972 Canada Yearbook).

[66] The Reports referred to in this paper are on file with the writer.

[67] *Sixty-Ninth Annual Report of the Canadian Medical Protective Association*, June 1970, at 17.

[68] *Seventieth Annual Report of the Canadian Medical Protective Association*, June 1971, at 15.

[69] *Seventy-First Annual Report of the Canadian Medical Protective Association*, June 1972, at 17.

[70] See Roemer, *Controlling and Promoting Quality in Medical Care* (1970), 35 Law and Contemporary Problems 284. (This author who is Professor of Public Health at the University of California, L.A. states: "there is no question that the threat of malpractice suits is an inducement to elevate the diligence of medical performance", *id.*, at 297).

many articles which warn doctors of their potential liability and stress the need for caution.[71]

(iii) *Alternative Means of Quality Control*[72]

Some will no doubt argue that regulation of medical practice and inducement of higher standards of care are best left to other forms of quality control.[73] The Ontario Committee on the Healing Arts was of the extreme opinion that "the malpractice action may be ignored in any realistic assessment of the adequacy of existing quality controls".[74]

Obviously the law of torts cannot be relied on as the only means of regulating the practices of the medical profession, bringing deficiencies to light and inducing higher standards of care by threat of sanctions. There are other systems which fulfil the above functions and each of these may be much more effective in this respect than tort law. However, the question is not whether the other means of control are more or less effective than tort law — nobody is suggesting that tort law should take their place. The question is whether they are so effective as to make tort law superfluous in this respect, or whether tort

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[71] See Roemer, *id.*, at 297. For a few examples of such articles see Fisher, *Medico-Legal Comments* (1949), 62 Can. Med. Assoc. J. 196; Fisher, *Thoughts on Changing Medico Legal Conditions* (1954), 68 Can. Med. Assoc. J. 73; Fisher, *Competence* (1952), 66 Can. Med. Assoc. J. 180; Hilton, *Medico-Legal Aspects of Anaesthesia* (1955), 69 Can. Med. Assoc. J. 641.

[72] Both of the functions of the malpractice suit which we have just examined lead to one end—the increasing of quality control. However, we feel that a clear distinction should be made between the two functions—tort law as a means for judicial review which may lead to regulation of medical practices and highlighting of deficiencies and tort law as a deterrent—not only because of the clear theoretical distinction between them, but also because we feel that although there is clear evidence that tort law does indeed fulfil the first-named function, we have indicated that in order to ascertain whether the malpractice suit has any deterrent effect, an empirical investigation would be essential. It is this writer's opinion that the failure to draw a distinction between the above two functions of the malpractice suit is the main reason why many have dismissed its value as a quality control device. By placing the accent on the efficacy of various sanctions against negligent doctors, they have concentrated solely on the deterrent function of tort law and have ignored the other function which we have examined (see e.g. Root, *supra,* note 1, who writes (at 636): "Whatever inducement the threat of malpractice action provides toward the exercise of professional care would be eliminated (by abolishing the malpractice suit—D.K.). The validity of this function of tort law, however, is questionable, and it is submitted that medical societies and criminal law are better qualified to provide such incentives through their sanctions." Cf. the statement by Crawford Morris quoted in note 64, *supra,* in which a distinction is drawn between malpractice litigation (which has had positive effects) and the threat thereof (which in Mr. Morris' opinion has not).

[73] See Root. *supra,* note 1 at 636; Haines, *supra,* note 1.

[74] *Report of the Committee on the Healing Arts,* Vol. 3 at 71. The Committee reached this conclusion after demonstrating the unimportance of malpractice litigation in Canada "when measured against the magnitude of the problem in the United States" (*Id.*). The Committee had details of the number of malpractice suits in Canada up until the year 1967, but, as we have noted, since that year the annual number of suits has increased (*supra,* note 19). It is possible that in order for the malpractice suit to be effective as a quality control device, the number of suits would have to be increased until an optimal number is reached, i.e. the number which would make the malpractice suit as effective as possible as a quality control device without it having the adverse effects which the upsurge in this type of litigation is said to have had in the United States.

law may have a place as a complementary system of control, or as one writer has put it "as a last resort".[75]

The main quality control devices which must be considered are:

1. Disciplinary action by the College of Physicians and Surgeons;
2. Quality control of practice in public hospitals;
3. The coroner's inquest.

1. *Disciplinary Action by the College of Physicians and Surgeons*

The College of Physicians and Surgeons is empowered to take action against doctors who are guilty of incompetence.[76] Although the sanctions which the College may impose probably provide a much stronger incentive than the fear of a tort law suit, in the overall picture of quality control the disciplinary role of the College has certain shortcomings:

1. Internal disciplining in a profession is never a pleasant task. "The entrant to the profession of medicine joins a fraternity" are the opening words of Medical Ethics, published by the British Medical Association,[77] and though the fraternity may wish to preserve its prestige by weeding out its incompetent members,[78] no member of the fraternity relishes the task of having to judge his fellow member and decide that he is or is not incompetent.[79] It is possible that professionals trying their fellow professional would tend to identify with him and may see things rather too much "from the side of the professional."

2. In a study conducted in Ontario by a group from Osgoode Hall Law School, an attempt was made to determine whether physicians who became aware of negligence on the part of a fellow physician would report the matter. The physicians were asked what they would do if while performing their duties at a hospital they were witness to an act by another doctor during his course of treatment of a patient which caused serious injury to the patient, it being

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[75] Roemer, *supra*, note 71.

[76] Section 34(3)(c) of *The Medical Act*, R.S.O. 1970, c. 268. This is a relatively new provision which was introduced by an amendment to *The Medical Act* in 1965 (S.O. 1965, c. 69). For a discussion of the development of the College's jurisdiction to discipline incompetent doctors see MacNab, *A Legal History of Health Professions in Ontario*, A Study for the Committee on the Healing Arts (1969) at 24-61. For a full review of the College's diciplinary powers see Grove, *Organized Medicine in Ontario*, A Study of the Committee on the Healing Arts (1969) at 161-84.

[77] See Bennion, *Professional Ethics* (London: C. Knight, 1969) at 20.

[78] See Goode, *supra*, note 13 at 198.

[79] This does not apply, of course, to doctors alone and is likely to be the case with any other group of professionals. In *Rondel* v. *Worsley*, [1967] 3 All E.R. 993, the House of Lords decided that a barrister is immune from a suit for professional negligence in the conduct of litigation. In reading the speeches of the law lords one cannot escape the impression that a sense of solidarity with their former colleagues at the bar must have had an effect on their stands in the matter. For further discussion of the effect which a feeling of fraternity between bench and bar has on malpractice suits against lawyers see *Attorney Malpractice* (1960), 60 Col. L. Rev. 1309 at 1312. The author of this note claims that the majority of decisions in malpractice suits against lawyers "reflect a superficial analysis that is almost certainly colored by the fraternal concern of the judiciary for members of the practising bar".

quite obvious that the other doctor was grossly negligent. Forty-two percent of the doctors wrongly thought that in such a situation they were required *by law* to inform the Hospital Discipline Committee, yet only 54.2% of the doctors claimed that in practice they would indeed inform the said Committee. 38.6% of the doctors claimed that they would inform the other doctor that he must report what happened to the patient or to the Hospital Discipline Committee. 6.5% of the doctors said they would inform nobody of the other doctor's conduct.[80] These figures tend to support the view that there are inherent difficulties in relying on doctors to fight incompetence among their colleagues.

3. It may indeed be true that the courts are not really competent to pass judgment on purely medical matters and that leaving the determination of standards of skill and care to the doctors themselves is unavoidable.[81] However, at least in those cases where, in the words of Baxter, C. J., "the opinion of one man is about as good as that of another",[82] the courts have been prepared to decide that the standards set by the medical profession were unacceptable and that adherence to such standards by the defendant doctors did not excuse them from negligence.[83] Some of these judicial decisions have led to changes in the practices of the profession.[84] Will this be achieved if the doctors themselves are the sole judges of their conduct?

The disciplinary powers of the College of Physicians and Surgeons have a central role to play in controlling the practice of medicine. However it seems clear that they cannot be relied on as the *only* means of control and must be supplemented by other means as well.

2. *Quality Control in Hospitals*

It would seem that the most significant form of control over the standard of competence of doctors in Ontario is the control exercised over the medical staff in public hospitals. There is no need to review the various mechanisms for maintaining high standards of medical practice in the hospitals.[85] It is quite clear that the importance of these mechanisms can hardly be overestimated. However, we submit that the system of quality control in the hospitals has certain deficiencies which should not be overlooked.

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[80] See Sharpe, *The "Conspiracy of Silence" Dilemma (Part I)* (1973), 40 Ontario Medical Review 25 at 30.

[81] See Fleming, *supra,* note 16 at 820; McCoid, *The Care Required of Medical Practitioners* (1959), 12 Vand. L. Rev. 549 at 607.

[82] *Taylor et al.* v. *Gray,* [1937] 11 M.P.R. 588 at 613.

[83] See *Crits* v. *Sylvester,* [1956] O.R. 132; *Taylor et al.* v. *Gray, supra,* note 82; *Lepine* v. *University Hospital Board* (1965), 50 D.L.R. (2d) 225, (reversed (1966), 57 D.L.R. (2d) 709); *Anderson* v. *Chasney,* [1949] 4 D.L.R. 71; *Penner* v. *Theobald* (1962), 35 D.L.R. (2d) 700. For a full examination of the influence of custom on the standard of care in negligence suits see Linden, *supra,* note 10, at ch. 3. Also see Weiler, *Groping Towards a Canadian Tort Law: The Role of the Supreme Court of Canada* (1971), 21 Univ. of Toronto L.J. 267 at 322 ff.

[84] We have noted above the effect which the decision in *Anderson* v. *Chasney* had on enforcing sponge counts in all operating theatres.

[85] For a review of quality control in Ontario hospitals see Grove, *supra,* note 76 at 65-81 and at 175-77.

First, all of the reservations which we expressed about the efficacy of the College's disciplinary control over doctors apply equally to the disciplinary control in hospitals: it is a system based on the control of doctors by doctors alone.[86]

Secondly, although in theory there is a high degree of regulation of the practice of medicine and supervision over the medical staff, we have no guarantee that in practice everything works that smoothly. In his study on "Organized Medicine in Ontario", when referring to a brief submitted by the College of Physicians and Surgeons to the Committee on the Healing Arts, in which the College painted a glowing picture of the position in hospitals, Professor Grove wrote as follows:

> Interpreted literally, this is, in almost all respects an overstatement (and might well evoke wry smiles from members of the profession). The machinery is *aimed* at securing that, so far as possible, the doctor in the hospital has privileges in keeping with his competence, but in practice it is acknowledged to be far from infallible; the supervision of quality of care by medical advisory committees often leaves much to be desired; the effectiveness of medical audit and tissue procedures is conditioned by pressure of work and staff shortages; and although great improvements have been made, it is well recognized that medical record keeping is still far short of what it should be.[87]

Finally, it should be noted that most of the malpractice cases which reach the courts are hospital cases. Of course, this is due to the fact that the more "suit-prone" fields of medicine such as surgery and anaesthetics are practised in hospitals alone. However, it also indicates that it is in this sphere of activity that supplementary means of quality control may be most needed. It has been argued in the United States that the influence of malpractice litigation is most strongly felt in the organization of medical staffs and other components of hospital operation. It provides a powerful stimulus to estab-

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[86]It is indeed true that the ultimate control of a hospital is in the hands of the Board of Trustees, a lay body. However, the actual control over the practice of medicine is in the hands of the heads of department and various committees of doctors such as the Medical Advisory Committee and the Tissue and Medical Audit Committee (both of these committees are mandatory in almost every Ontario public hospital): See Grove, *supra,* note 85.

[87]*Id.,* at 201.

We may add that while in the large hospitals one of the problems may very well be that the pressure of work and staff shortages prevent the supervision being what it ought to be, in the smaller hospitals a different problem exists. When the medical staff of a hospital is small in number, there may be a tendency to have a rotation system to fill the various posts in the hospital. Many of the doctors may also work together outside the hospital, and even if they do not work together professionally, they are likely to maintain fairly close personal relationships. All this may make it very difficult and embarrassing for the doctors to be critical of each other's work, even when they are filling an official position, such as chief of the medical staff. Is it realistic to expect a doctor to suggest that his partner's privileges at the hospital be cancelled because of the latter's incompetence? In the coroner's inquest into a most unfortunate case which received wide press coverage a few years ago, it was revealed that members of the medical staff in one of Toronto's larger hospitals had failed to act to have the privileges of a doctor they knew to be incompetent cancelled because, it seemed, of the hardship they would have caused the said doctor (see Globe and Mail, Toronto, Feb. 25, 26, 27, 28, 1964). Such "restraint" is probably even more likely in a smaller hospital. For a review of the staff organization in a small Ontario hospital see Grove, *supra,* note 76 at 73-76. (Virtually all of the fifteen doctors on the medical staff in the hospital described by Grove belong to one of two clinics).

lishing rules for encouraging thorough work and is an inducement to careful medical record keeping, which in turn helps to promote better continuity of medical care.[88]

3. *Coroner's Inquest*

Under the Coroner's Act an investigation by a Coroner of a death allegedly due to malpractice may lead to a Coroner's inquest.[89] Like the tort suit, the coroner's inquest may lead to a review of and change in the regulations accepted by the medical profession.[90] Following a coroner's inquest in which the jury found that the death of a young woman had been caused by an instrument left in her body after an operation, the chief coroner of Toronto stated that one of the lessons to be learned was that instrument counts should be mandatory in all operating theatres.[91]

An obvious limitation on the efficacy of coroners' inquests is that an inquest may be held only where suspected malpractice has led to the death of a patient. Fortunately, death does not follow every act of incompetence or negligence of a doctor. Furthermore, while the tort action may be initiated by the victim of the doctor's negligence, a coroner's inquest is held only after the coroner has conducted an investigation and decided that an inquest is necessary. Once a complaint has been laid, the matter is taken out of the private individual's hands.

It is submitted that the regulation of medical practice and control over the medical profession cannot be left entirely to other mechanisms[92] and that tort law has an important role to play here. It seems to us that the tort suit and the other mechanisms are not completely co-terminus and that the former may be useful where and when the other mechanisms fail.

(c) *The Tort Action — A Flexible Framework*

We have emphasized the importance of the tort action as a mechanism for resolving conflicts in values between the medical profession and the rest of society. Tort law provides a wide and flexible framework for assessing human activities, and this makes it suitable, not only as a means of controlling the abuse of power, but also as a vehicle for regulating human conduct in

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[88] See Roemer, *supra,* note 70 at 297.

[89] *The Coroners Act,* R.S.O. 1970, c. 87.

[90] See Ontario Law Reform Commission, *Report on The Coroner System in Ontario* (1971). The Commission states: "The fact remains that the coroners' juries have on occasion provided a catalyst for the adoption of significant new lifesaving practices by medical institutions and medical personnel". (*Id.,* at 31).

[91] Globe and Mail, Toronto, February 28, 1964.

[92] It has been argued that the criminal law could fulfil the function now fulfilled by tort law in respect to quality control (see Root, *supra,* note 2 at 636). As we have indicated in *supra,* note 72, this argument ignores the distinction we have drawn between the two functions of tort law related to quality control—tort law as a deterrent and tort law as a regulatory device. Although criminal sanctions may serve as efficient deterrents against specified practices (such as practices defined in the Regulations passed under the Food and Drugs Act) in our opinion, it is not suited to fulfil the general regulatory role which we have suggested that tort law may fulfil.

spheres of activity where no other form of regulation exists.[93] This aspect of the law of torts should equip it to deal effectively with a dynamic and developing field such as medical science, where specific regulation cannot keep pace with the rapid emergence of new problems. Two areas in which this capacity of tort law may be particularly important are experimentation with human beings and congestion in hospitals.

(i) *Experimentation with Human Beings*

As yet no clear legal rules have been established to define the legitimate parameters of human experimentation. It has been argued "that the system of legal controls should be based for the most part not on detailed statutory administrative rules applicable to all experiments, but on standards allowing leeway for the exercise of judgment . . .".[94] While the law should not be the only system of control, there is much to be said for the view that the "common law is the ultimate legal guardian of the interests involved in experimentation. Where there is a serious debate concerning the propriety or the necessity of certain procedures, where there is a real conflict of interests, an appeal to putatively relevant concepts of the common law provides authoritative standards for judgment."[95]

(ii) *Congestion in Hospitals*

It has been argued that the continued expansion of medical care and treatment from the doctor's private surgery or consulting rooms to the hospital will result in more and more accidents.[96] The possibility of such a development argues for the retention of the malpractice action, not for its abolition. Again, laxness in hospital procedures and other acts or omissions which lead to accidents may be brought to light by tort actions. The courts will have to determine the extent to which congestion excuses practices otherwise regarded as negligent. They will also have to decide how far doctors may go in relying on paramedical personnel in treatment of patients.[97] We may eventually reach the stage where much of this is governed by specific legal rules and regulations (as in the highway traffic field). However, until this occurs, tort law would seem to be the most convenient system of regulation.

(3) *Possible Effects of Granting Immunity from Negligence to Doctors*

It is also possible that the grant of immunity to doctors from liability for negligence would have an adverse psychological effect on their patients. There is a real danger that patients who suffered "medical accidents", especially in cases of clear negligence by doctors (and such are bound to occur) would feel

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[93] For an illuminating discussion of the function tort law may play in the future in controlling the abuse of power and providing solutions to problems which "demand comprehensive solutions and yet pose even more difficulties in achieving them" see Shapo, *Changing Frontiers in Torts: Vista's for the 70's* (1970), 22 Stanford L. Rev. 330; Linden, *supra*, note 10.

[94] Jaffe, *Law as a System of Control* (1969), 98 Daedalus 406 at 414.

[95] *Id.*, at 415.

[96] See Haines, *supra*, note 1.

[97] For a discussion of this problem in California see Burton, *Tort Liability and the California Health Care Assistant* (1972), 45 Southern Calif. L. Rev. 768.

that doctors were not as careful as they had been before.[98] It matters little whether the doctors would in fact be less careful. If the public believed that the special immunity enjoyed by the medical profession was contributing towards a feeling of indifference to "medical accidents" on the part of doctors, this could be very damaging to the relationship between the medical profession and society.

(4) *Differential Professional Accountability*

In many cases the medical malpractice suit is based on contract as well as tort.[99] If the professional liability of doctors for negligence is abolished does this mean that the contractual liability of doctors will be eliminated as well? It would be rather ridiculous to grant a doctor immunity from liability in tort and allow a suit against him grounded in contract. A likely solution would be the adoption of the language of section 48 of *The Medical Act*.[100] Section 48 places a limitation on any actions against a doctor "for negligence or malpractice, by reason of professional services requested or rendered".

Before adopting such a solution, we should consider very carefully the policy implications of granting immunity from professional liability to one profession and not to the others. Why should lawyers, engineers and accountants be liable to their clients for negligent performance of their professional duties, if doctors are not? Such a distinction in the treatment of the professions would appear to create a serious anomaly in policy: if the professional's negligence is likely to create only economic loss, the professional is liable for negligence, while if bodily injury may result from the professional's negligence he is immune from liability. The anomalous nature of such a solution is apparent in the light of the provision in the *Solicitors Act* which prevents a solicitor from contracting out of his liability for professional liability.[101]

C. THE COMPENSATION PROBLEM

It has been suggested that an insurance scheme be established which would provide compensation for all patients in whose cases an "untoward result" follows medical treatment.[102] Apart from the problem of determining

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[98] In his article in which he advocates abolishing the malpractice suit against hospitals, Ehrenzweig deals with another psychological factor—the need to respond to the victim's demand for revenge which Ehrenzweig regards as being no less real than the victim's rational needs. For this reason Ehrenzweig favours retaining the malpractice suit in cases of criminal negligence: see Ehrenzweig, *supra*, note 1 at 290.

[99] See Nathan, *Medical Negligence* (London: Butterworths, 1957) at 10-11.

[100] R.S.O. 1970, c. 268.

[101] R.S.O. 1970, c. 441, section 24. Perhaps this solution would be more acceptable if the victim of a doctor's negligence were to be compensated under the compensation scheme on the same scale as the compensation he would have received in a suit against the doctor. If this were the case, the distinction could be rationalized by saying that the victim of a doctor's negligence suffered no loss. However, if the victim were to receive less than he would have received in a common law suit against the doctor the differential treatment of the professions would be clear. The victim would have to bear the loss caused by a doctor's negligence himself whereas if another professional retained by him were negligent, the professional would bear the loss.

[102] See Haines, *supra*, note 1; Root, *supra*, note 1.

the meaning of the term "untoward result", this suggestion raises a question of basic principle. If the emphasis is placed on *victims* of misfortune, why should the patient suffering an "untoward result" be singled out for special treatment? What justification is there for providing for such a patient if no provision is made for the patient who suffers loss, though there was no "untoward result"?

Let us compare two cases. "A" undergoes an operation which has an "untoward result". In consequence thereof "A" loses six weeks' earnings. "B" undergoes an operation. The operation goes smoothly, and there is no "untoward result". However, as is normal following "B's" type of operation, "B" is hospitalized for six weeks after the operation and loses six weeks' earnings. Why should "A" be compensated and "B" not? The "ordinary" sick and injured would seem to create a much greater social problem than those who have been victims of "medical accidents".

Many of those who have considered the compensation systems as an alternative to the tort suit have been troubled by the distinction in treatment between accident victims and victims of natural events. Professor Atiyah has questioned the justification for such a distinction:

> reform of the whole compensation process, which can hardly be delayed much longer, is going to raise the question whether accidental injuries, and natural disabilities should be treated in the same way. So long as the personal responsibility of some individual (if nominal) defendant is insisted on as a condition of entitlement to compensation, it naturally follows that only accidental injuries will (in general) be compensated. But when we get to the stage . . . in which the compensation is paid by the public in one way or another, and not by any individual, the justification for distinguishing between accident and natural disability or disease becomes less obvious.[103]

It has been argued that there are indeed grounds of policy for distinguishing between compensation for victims of accidents and of disease.[104] The basic premise of this argument is that a compensation system must contribute towards the goal of reducing the number and severity of accidents.[105] We would question the relevance of this theory to the field of medical accidents.

There are two ways of reducing the number and severity of accidents. One is to discourage those activities which result in accidents, and the other is to encourage more care in the course of these activities.[106] By maintaining a distinction between the costs of accidents and the costs of disease, we can impose the costs of accidents on those activities which result in them. The theory is that if the costs of a given activity rise, that activity will be discouraged. For example, if we impose the costs of accidents which result from driving sports cars on the activity of driving sports cars, we should discourage the driving of sports cars. If we externalize these costs by eliminating the

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[103] Atiyah, *supra*, note 3 at 478. Also see Ison, *supra*, note 3 at 55; Blum and Kalven, *Public Law Perspectives on a Private Law Problem—Auto Compensation Plans* (1964), 31 Univ. Chicago L. Rev. 641 at 675.

[104] See Calabresi, *The Decision for Accidents: An Approach to Nonfault Allocation of Costs* (1965), 78 Harv. L. Rev. 713 at 715.

[105] *Id.*

[106] *Id.*

distinction between the victims of sports car accidents and, for example, the victims of cancer, we do nothing to discourage the driving of sports cars.

It seems to us that a theory which distinguishes between accident victims and victims of disease has no application to the field of "medical accidents". "Medical accidents" occur while attempts are being made to alleviate disease or injury. By discouraging the activity which results in these accidents, we would not be helping to reduce the number of the injured and sick, nor the severity of their injuries or disease. On the contrary, we would increase them.

We cannot hope to reduce the number and severity of medical accidents by discouraging the activity which results in the accidents — we can only encourage more care in the course of the activity.[107] A compensation system which provides compensation for the victims of "medical accidents" and not for the victims of disease would be of no help in this respect.

The question of financing has proved to be a major bone of contention in the debate over the question of road accident compensation schemes in the United States. Professor Calabresi of Yale has argued that the principal function of accident law is to reduce the cost of accidents and the costs of avoiding accidents.[108] The way in which accident costs are allocated must be determined with this principal function in mind. Professors Blum and Kalven, on the other hand, have argued that the basic issue in determining how costs are to be allocated is justice. Their argument is that

> if a proposal fails to satisfy a sense of justice in the allocation of its costs, it will . . . be decisively impeached regardless of how fully it may achieve its other goals.[109]

It is for this reason that Blum and Kalven reject road accident compensation schemes which would be paid for by motorists.[110] We submit that the proposal to abolish the tort action against doctors and to finance a "medical accident" compensation scheme by adding an insurance premium to doctors' fees and hospital bills has been analyzed neither in the light of all the goals to be

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[107] Calabresi points out that the distinction between "activity" and "care" is not always clear. If we define "activity" narrowly or "care" very broadly, the concepts tend to merge. (Calabresi, *supra,* note 104). However, even if we were to define "activity" in the medical field as narrowly as practical, we would not overcome the difficulty we have discussed. Our premise is, and must be, that when a specific "risky" form of medical treatment is undertaken, the aim is to alleviate disease or injury, and that if such forms of treatment were not undertaken, we would have more serious disease or injury.
One could put the argument we have advanced here another way: in order for enterprise liability to be effective as a "general deterrent", there must be a viable alternative to the activity which is deterred. By placing accident costs on an activity we make that activity more expensive. If an alternative activity exists which is safer than the first but was more expensive until the accident costs of the first activity were internalized, people will now choose the safer activity. (See Weiler, *Defamation, Enterprise Liability and Freedom of Speech* (1967), 17 U. of Toronto L.J. 278 at 297). "Risky" medical techniques are adopted not because of their price but because they are regarded as the most effective techniques in the given circumstances. There are not viable alternatives available.

[108] *Id.,* at 713; Calabresi, *The Costs of Accidents* (New Haven and London: Yale University Press, 1970) at 26.

[109] Blum and Kalven, *The Empty Cabinet of Dr. Calabresi: Auto Accidents and General Deterrence* (1967), 34 U. Ch. L. Rev. 239 at 242.

[110] Blum and Kalven, *supra,* note 103 at 54.

achieved in accident law, nor from the perspective of justice. Such an analysis is beyond the scope of this paper. We shall, however, point out a few of the issues which merit fuller examination:

1. Calabresi distinguishes between three sub-goals into which the major goal of accident law — the reduction of costs — can be divided. The "primary" sub-goal is reduction of the number and severity of accidents. The second sub-goal is concerned with reducing the societal costs resulting from accidents by risk-distribution. The third sub-goal involves reducing the costs of administering treatment of accidents.[111] A compensation scheme such as the one advocated by Mr. Justice Haines[112] places most of the stress on the second of these sub-goals, and some on the third. No attempt is made to determine how it would perform in relation to the "primary" sub-goal.

We have tried to demonstrate that the number and severity of accidents cannot be reduced by discouraging the activity which results in these accidents. One way to help fulfil the primary goal is to retain the tort action (alongside the compensation system) in the hope that judicial review over the practices of the medical profession will, by bringing deficiencies in medical practice to light, help to reduce the number and severity of medical accidents.

2. On what basis are premiums to be paid and on what basis is compensation to be paid? Will the premiums be on a flat rate basis or dependant upon the risk involved? Which risk? The risk in the type of treatment or the loss likely to be incurred if there is an accident? Will the man who undergoes brain surgery pay the same premium as the man who undergoes treatment which is as expensive as brain surgery but not nearly as risky? Will the man who earns $12,000 a year pay the same premium as the man who earns $75,000?

We shall now consider the proposal to finance the insurance scheme by adding a few cents to every patient's fee or hospital bill. If every victim of a medical accident under such a scheme were to be compensated for his economic loss we would be creating a scheme whereby the poor would subsidize the rich. The man who earned $6,000 a year would pay the same premium as the man who earned $75,000; yet if they suffered the same injuries and each lost one month's earnings, one would receive $500 and the other $6,250. On the other hand, if we compensate all on the same basis, for example, according to a schedule unrelated to actual loss, what provision should be made for those whose loss is not fully compensated? Should they have to bear the loss themselves? These questions deal with matters of detail, but they are crucial to the whole compensation scheme, and they must be carefully considered.

3. Is the problem merely one of providing monetary compensation for accident victims, or should we aim at rehabilitation of the injured as well? The approach in Workmen's Compensation has been to provide the means of rehabilitation for victims of work accidents. Should this approach not be adopted for victims of disease and other types of accidents as well?[113]

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[111] Calabresi, *supra*, note 108, at 26-28.

[112] Haines, *supra*, note 1.

[113] See McRuer, *The Motor Car and the Law* (1966), 4 Osgoode Hall Law Journal 54 at 74.

D. CONCLUSION

Although in some spheres of activity the tort suit may have outlived its usefulness as a compensation system and should perhaps be abolished, in the sphere of medical practice the tort suit may still fulfil useful functions. It provides a means of controlling the power of the medical profession, and it adds to the quality control of medical practice. When examining the proposal that the malpractice suit be abolished in Ontario and replaced by a compensation scheme, we must assess the value of these functions. We should also keep in mind that medical science is developing rapidly, and new problems are forever emerging which defy specific regulation in advance. Tort law can serve as a convenient regulatory device.

The need to devise a system to compensate all victims of medical accidents seems clear. However, we have argued that the need to compensate such victims is no greater than the need to compensate victims of disease, and that there are no good grounds of policy for distinguishing between the victims of medical accidents and the victims of disease. It would seem therefore that there is little justification for creating a special compensation scheme for victims of medical accidents. They should be included in a general compensation scheme for the injured and the sick.

Even if a scheme is devised to provide compensation for all victims of medical accidents, this does not necessarily mean that the malpractice suit should be abolished. The compensation scheme would probably not compensate the victim as generously as tort law, and the tort suit could be retained as a complementary action.

Retention of the tort suit alongside a compensation scheme by allowing a victim of an accident to sue the tortfeasor for the difference between his damages under the law of torts, and the compensation received from the scheme, is not necessarily meant to provide a compromise between those who favour the tort suit and those who would abolish it entirely. In the medical field, by adopting a solution which Professor Linden has called "peaceful coexistence"[114] we may achieve the proper balance between the need to provide compensation for victims of misfortune and the need to retain a system which fulfils the functions that the tort suit fulfils.

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[114] Linden, *supra*, note 56 at 459.