MEDICAL MALPRACTICE LITIGATION
IN CANADA

by

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The purpose of this study is twofold:

1. to present a descriptive analysis of the current state of medical malpractice litigation in Canada; and

2. to present and discuss possible alternatives to medical malpractice litigation.

It is a descriptive study utilizing information obtained from questionnaires, interviews, annual reports and other documents pertaining to medical malpractice litigation.

The study shows that the purpose of medical malpractice litigation is the assignment of the responsibility for the carrying of costs of losses and injuries resulting from medical treatment. It also plays a number of secondary roles, the most notable being a mechanism by which patients may hold doctors accountable for their professional behaviour. In this respect, medical malpractice litigation is unique amongst the other mechanisms of accountability in that it provides the only means by which the patient may obtain compensation for losses incurred as a result of medical treatment.

Medical malpractice claims may be submitted under two causes of action: "negligence" and "trespass to the person". A cause of action of "negligence" requires that the plaintiff (patient) prove that his or her loss is the result of a breach of a "duty of care" by the defendant (doctor). In order to prove "trespass to the person", the plaintiff must show that no consent or an invalid consent was obtained by the defendant.

An examination of the process of medical malpractice litigation in Canada indicates that barriers exist to malpractice action. Barriers viewed as being unacceptable are: financial cost, lack of knowledge and
confidence in the legal system, and lack of legal justification. The unacceptable rating of this latter barrier is due to a number of factors which are felt to have an additive impact against the plaintiff.

In view of the apparently large number of medical accidents; the fact that many of these accidents do not fall within the guidelines of "negligence" and "trespass to the person"; and the fact that strong barriers exist to the successful completion of eligible malpractice claims, medical malpractice litigation is viewed as an inadequate means of compensating patients for their medically caused losses. In addition, when using Calabresi's concept of "accident cost reduction", medical malpractice litigation is found to be ineffective in reducing the costs of medical accidents.\footnote{Guido Calabresi, "Medical Malpractice, Closing the Circle," \textit{UNIVERSITY OF TORONTO LAW JOURNAL}, forthcoming.}

Three alternatives to litigation are examined: social insurance, no-fault insurance, and a scheme developed by Calabresi. Calabresi's scheme is found to be most effective in meeting the prescribed goals of the system.

Analysis of past trends in the volume and cost of medical malpractice litigation in Canada reveal that, accounting for the number of physicians at risk, there has been on average a 7\% increase in the volume of new claims over the last 15 years. On the other hand, the considerable increase in costs can be explained by the increase in the number of cases in process and by inflation factors. Since only 35\% of the costs may be attributed to awards and settlements, the analysis suggests that costs will continue
to increase if the volume of new claims continues to increase.

Overall, the study suggests that Calabresi's scheme for the partial compensation of medical accident costs should be tested through a pilot project. In addition, a number of suggestions for reforming the process of medical malpractice litigation are proposed.
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CHAPTER I

MEDICAL MALPRACTICE LITIGATION IN CANADA - THE STUDY*

Introduction

The extreme imbalance between the power and authority of the provider (the doctor) and that of the consumer (the patient) of medical services, has been well established.¹ ² This power and authority of the physician stems from both the technical and esoteric nature of medical knowledge as well as from the emotional effects engendered by the life and death implications of the administration of this knowledge. These two factors make it difficult for the patient, not only to make rational decisions concerning the nature of the care he is to receive, but also to assess the quality of that care. The patient, therefore, is generally at the mercy of the doctor.

The same factors are also responsible for the position of power that the profession of medicine (as a group) occupies in society. In Canada, medicine has been granted monopolistic control over its practice through its power to set and enforce standards for entry to the profession as well as through its disciplinary powers. Presumably, these powers have been granted in the belief that doctors, and only doctors, are able to set medical standards and are able to judge the clinical capabilities of other doctors.³

Medicine, therefore, possesses two forms of power which emanate

*Footnotes follow each chapter
largely from the same base: the technical and esoteric nature of medical knowledge. Klein distinguishes between these forms of power as follows:

"there is power in the sense of manipulating the system in which we live: the power to shape our environment in the widest sense, political, social and economic. Equally, though, there is power in the sense of manipulating the individual within the system; the power to shape the way the system deals with people who come in contact with it."4

Given that the profession of medicine and the individual practitioner have been granted significant control over the practice of medicine and over the medical treatment of the patient respectively, how does society ensure that these significant powers are not abused?

There exists in Canada, a number of different, but largely unrelated mechanisms, by which doctors may be held accountable. These include such options as withholding fees, changing doctors, disciplinary proceedings of licensing bodies and medical malpractice litigation. For the purpose of this study, all such mechanisms of physician accountability will be considered components of a system to be known as the "system of medical accountability".

Figure 1 presents a simplistic outline of the process of medical accountability. Although by no means comprehensive, it does provide a useful framework for examining the system.

The flow chart suggests that problems requiring practitioner accountability flow from the doctor-patient encounter. The ideal outcome of this encounter would be the optimal treatment of the patient given the patient's condition, the resources available and the state of technology. In addition, for the outcome to be truly ideal, the patient should be satisfied with the encounter. The flow chart looks at the opposite situ-
Figure 1- Flow Chart of the Process of Medical Accountability

Start

Doctor Patient Encounter

Patient Dissatisfied with Encounter?

Yes

Patient Takes Action?

No

Stop

Yes

No

Patient Dissatisfaction Resolved?

Yes

Stop

No

Patient Directed Accountability

Peer Directed Accountability

Social Accountability
when patient dissatisfaction occurs.

Dissatisfaction provides the basic ingredient for the entry of the patient into the medical accountability system. Clearly, the patient who is satisfied with the encounter has no grounds or motivation to hold his or her doctor accountable. On the other hand, the dissatisfied patient may have reason for holding the doctor accountable but may decide not to pursue any further action. Entry into the medical accountability system, therefore, requires not only that the patient be dissatisfied with some aspect of the encounter with his or her physician, but also that the patient be aware of, and be willing to initiate, further action.

Patients who decide to take further action have a number of alternatives from which to choose. They may take personal action such as changing doctors or withholding payment of fees. On the other hand, they may initiate proceedings of peer review by relaying a complaint to the medical licensing agency or to the hospital where the doctor is appointed. These two directions have been labelled on the flow chart as mechanisms of "patient directed accountability" and "peer directed accountability" respectively. The final and most extreme option open to the patient is to sue the doctor by initiating litigation proceedings. As will later become apparent, litigation may be viewed as a mechanism of "social accountability".

Although it would be desirable to study the complete system of medical accountability, such a study, if it were done well, would be beyond the scope of a Master's thesis. The intention in this study, therefore, is to examine, in depth, one mechanism of medical accountability, namely medical malpractice litigation.
The Purpose of the Study

The purpose of this study is twofold:

1. to present a descriptive analysis of the current state of medical malpractice litigation in Canada;
2. to present and discuss possible alternatives to medical malpractice litigation in Canada;

The Approach of the Study

The study will descriptive, using information obtained from questionnaires, interviews, annual reports and other documents pertaining to medical malpractice litigation.

Due to the focus of the study on physician accountability, the study will concentrate on medical malpractice litigation as it pertains to doctors. Although this effectively excludes other sectors of the health care system from the study, it is hoped that the results of the study will be applicable to the whole health care system.

1. An Overview of the System of Medical Accountability in Canada

Before focusing on medical malpractice litigation, it will be useful to get an overview of the complete system of medical accountability. The approach to developing this overview will be to follow the flow chart represented in Figure 1. There will therefore be:

(a) an examination of the nature and dynamics of the doctor-patient relationship including an examination of the causes of patient dissatisfaction;
(b) an outline and discussion of mechanisms of patient directed accountability;
(c) an outline and discussion of mechanisms of peer directed accountability; and
(d) an outline and discussion of mechanisms of social accountability

2. Descriptive Analysis of Medical Malpractice Litigation in Canada

This section will comprise the bulk of the study. It will be divided into the following components:

(a) The Purpose and Effects of Medical Malpractice Litigation

As a process of law, medical malpractice litigation may be seen as serving one or several social purposes. It will, therefore, be examined within the larger context of the "law of torts" and the prevailing arguments concerning the purpose of the "law of torts" will be presented with specific reference to medical malpractice litigation.

Although medical malpractice litigation may be seen as having an intended social function or purpose, it may also be seen as having unintended functions or effects. These additional implications will be presented and discussed.

(b) Defining Medical Malpractice

An outline of the court's current definition of what behaviour comprises medical malpractice will be presented.

(c) The Process of Medical Malpractice Litigation in Canada

Every doctor-patient encounter has the potential to result in a medical malpractice suit or claim. The process by which this action develops will be examined with the assistance of a flow chart. Particular emphasis will be on determining and examining potential barriers to litigation. It should be noted that there is no intention to examine the technical legal procedures and process.

This section will be concluded with an examination of the extent
of medical malpractice litigation in Canada. Past trends in the amount and cost of litigation will be examined using data collected by the Canadian Medical Protective Association. Allowance will be made for variables such as number of doctors at risk and inflation factors.

3. Alternatives to Medical Malpractice Litigation in Canada

The preceding section will have clearly outlined the functions that medical malpractice litigation serves as well as apparent failings in the system. Medical malpractice litigation will, therefore, provide a useful benchmark against which possible alternatives may be compared.

The ultimate alternative to medical malpractice litigation is the elimination of behaviour by doctors which could be construed as medical malpractice. Processes by which this could be achieved will be discussed.

Alternatives to the process of medical malpractice litigation will then be presented and compared. An example of such an alternative is a scheme of medical compensation similar to worker's compensation plans.
FOOTNOTES - CHAPTER I


CHAPTER II

THE SYSTEM OF MEDICAL ACCOUNTABILITY - AN OVERVIEW

The Doctor-Patient Encounter and Patient Complaints

The relationship of the patient to the doctor has been characterized as one of dependence. The model suggests that the patient is exceedingly limited in his ability to assess his health problems and to choose appropriate resources to handle those problems. Consequently, the doctor, ascribing to a humanitarian code of ethics, acts on behalf and in the best interests of the patient to ensure that he receives the necessary medical care and treatment. The relationship, however, is not totally one-sided. The doctor, in most instances, is an entrepreneur who's livelihood depends on his ability to attract and maintain a continuing clientele. If he is to be successful, a doctor must not only minister to the medical needs of his patients, but also satisfy them. Unfortunately, these two goals of optimal medical treatment and patient satisfaction are not always congruent.

It is apparent that the physician and the patient view the doctor-patient encounter from differing perspectives. The doctor "looking from his professional vantage point, preserves his detachment by seeing the patient as a case to which he applies the general rules and categories learned during his protracted professional training". His primary concern is with the elimination of the patient's medical complaint and, consequently, his orientation is towards the overall medical outcome
of the encounter. The patient on the other hand, is personally and emotionally involved in what happens. He not only requires medical treatment but also understanding, comfort, support and an explanation of his medical problem and its proposed treatment. Although the patient is also concerned with the outcome of his medical encounter, his focus tends to be on the process of the encounter. It would therefore be expected, as suggested by Donabedian, that patients would judge and evaluate physician performance primarily by process criteria rather than outcome criteria.

Friedson in his study of "Patients' Views of Medical Practice", found that patients used two interlocking criteria to evaluate health services:

"First they felt, good medical care requires technical competence. Second they felt, good medical care requires an interest in the patient so that he obtains not only emotional satisfaction from the practitioner, but also the impression that competence is exercised in more than a routine way".

Although it might be expected that outcome criteria would be important in patient's evaluation of technical competence, process criteria were just as, or more important. For example, he found that the way that history-taking and physical examinations were performed, played a major role in patients' judgements of technical competence. Judgements of "interest in the patient", as might be expected were based primarily on process criteria. It is interesting to note that "questions of competence were raised far less than questions of interest". This finding coincides with that of Klein in his study of "Complaints Against Doctors" in Great Britain. Table I is a compilation of his results. It indicates that approximately eleven per cent of the complaints received by the complaints
handling machinery concerned a variety of matters, the majority concerning the quality of the process of the encounter.

Table I - Profile of Category of Complaints in NHS by Category of Complaint

<table>
<thead>
<tr>
<th>Complaint</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate examination or inadequate/incorrect treatment</td>
<td>10.9</td>
</tr>
<tr>
<td>Manners and remarks of practitioners</td>
<td>19.9</td>
</tr>
<tr>
<td>Manners and remarks of receptionists</td>
<td>14.9</td>
</tr>
<tr>
<td>Failure or delay in home visit</td>
<td>14.7</td>
</tr>
<tr>
<td>Dissatisfaction with appointments system</td>
<td>7.6</td>
</tr>
<tr>
<td>Failure to refer to hospital or specialist</td>
<td>5.3</td>
</tr>
<tr>
<td>Inability to contact practitioner by telephone</td>
<td>3.8</td>
</tr>
<tr>
<td>Other</td>
<td>22.9</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The above analysis suggests that patient complaints concerning a doctor tend to refer to the content and process of the doctor-patient encounter. Complaints concerning a doctor's competence occur less frequently.

There have been a number of studies which have tested patient satisfaction. In most cases, these have reported generally high patient satisfaction, although several studies have reported a lower level of satisfaction with group practices as compared to solo practitioners. In a questionnaire survey of mothers' opinions, Deisher et al found
that mothers were very satisfied with doctor’s interest, examination time and his willingness to receive telephone calls, etc. Areas of dissatisfaction included fees, house calls and waiting time. Gerst et al, in the study of a government employee’s medical plan, found that singles were significantly less satisfied than married participants in the plan. Linn found that young adults (18-25) were the least likely age group to be satisfied. Another interesting finding by Linn was that "Patients who were more satisfied with living in their community were significantly more likely to be satisfied with their medical visit as well as their interactions with doctors than patients who were less satisfied with their community life". Linn suggests that perhaps "dissatisfied patients are dissatisfied people and that one major determinant of patient satisfaction is the cognitive style or personality of the patient".

As suggested in Chapter I, the requirements for entry into the system of medical accountability requires not only that the patient be dissatisfied with some aspect of the doctor-patient encounter, but also that the patient be aware of and be willing to initiate further action. Ignorance of alternatives of accountability open to the patient no doubt reduces the potential for action. This is illustrated by the increase in complaints received by the College of Physicians and Surgeons of Ontario when the Health Disciplines Act was promulgated. At that time, the new system of handling complaints was well publicized throughout the province. It is interesting to note that the annual number of complaints received by the College since that time, has gradually reduced. One might surmise that this is in response to the recent lack of publicity.

The second reason for dissatisfied patients not entering the system of medical accountability is the cost, both temporal and financial in
pursuing a complaint. In the final outcome, the decisions to pursue a complaint is a value judgement by the patient as to whether the resolution of the complaint is worth the time, effort and money required.

In this section, I have briefly reviewed the nature of the doctor-patient relationship and the causes of patient complaints. In the following sections of this chapter, the various mechanisms of medical accountability will be discussed.

Patient Directed Accountability

The patient has several options by which he may directly hold the doctor accountable. These include the expression of displeasure, confronting the doctor, withholding payment of fees, changing doctors and litigation.

1. The Expression of Displeasure

   Earlier in this chapter, it was noted that in most cases, the doctor is dependent upon his patients for his livelihood. This dependence places a certain amount of leverage in the hands of the patient to manipulate the doctor's actions. Human behaviour provides the patient with a variety of ways by which he may express his displeasure with his doctor's actions. Some are subtle such as raised eyebrows or a frown, others such as crying, are obvious. Use of these modes of behaviour often allows the patient to manipulate the encounter so that ultimately he is more satisfied with the result. Such manoeuvres may be in the best interests of the patient and result in the early discovery of a major medical problem. On the other hand, it may lead to the unnecessary utilization of laboratory tests and often unnecessary prescribing of drugs. Friedson suggests
that the physician may in turn manipulate the patient's expectations 
and cites the example of the prescribing of harmless placebos. 13

2. **Confrontation**

Open confrontation is probably used infrequently compared to the subtle manipulation described above. Most often, confrontation would develop out of patient anger with the doctor. As Burstein suggests in a guide to medical students concerning the handling of doctor-patient encounters:

"Anger in patients can be particularly troublesome. It can provoke a rejection from the doctor or other member of the health team that sends the patient on a shopping expedition, often wasting valuable prior work! It can be sufficiently abrasive to the doctor to lead him to avoid the patient or, in other ways to blur his judgement in the clinical situation". 14

He goes on to suggest that anger may be expressed openly in the form of a direct challenge (confrontation) or in a disguised indirect form.

It is unfortunate that confrontation tends to be destructive since honest and open confrontation has the potential to lead to a new understanding between the two opponents as to each other's positions. In the case of the patient, disputes based on misconception and misunderstanding would be settled. In the case of the doctor, it would provide useful feedback of his patient's perceptions of his practice.

3. **Non Payment of Fees**

Non payment of fees provides a traditional mechanism by which the patient may hold the doctor accountable. In most instances in Canada, doctors bill and receive reimbursement directly from third party provincial health insurance agencies. The removal of the patient from the transaction makes it difficult if not impossible for him to withhold fee
payment.

A letter (Appendix A) requesting an outline of how they handle requests for withholding fee payments was sent to each of the provincial health insurance agencies. Despite two mailings, replies were received from only seven of the ten provinces. The replies universally reported that requests to withhold fees are infrequent. In almost all cases, such requests are sent to the provincial licensing bodies since the complaint is generally one of quality of care. The only situations cited where fees would be withheld or returned, is where it is established that the doctor did not provide the service. It is interesting to note that legally, the insuring agencies would not be placing themselves in jeopardy if they withheld payment at the request of the patient since the doctor's contract is with the patient, not with the insuring agency.¹⁵

A number of the provincial health insurance plans provide doctors with the option of either billing the agency directly at the designated fee, or billing the patient who then receives partial reimbursement from the agency. In the latter case, the patient could withhold payment of fees. Using Ontario as an example, only 10% of the doctors bill patients directly¹⁶ and consequently, the majority of patients in Ontario are unable to withhold fee payments. It is likely that the situation in other provinces resembles that of Ontario.

In conclusion, withholding fees is, generally no longer a mechanism by which patients in Canada may hold the doctor accountable.

4. Changing Doctors

There can be no doubt that many patients express their displeasure with a doctor by never returning to him. From the consumer's viewpoint,
changing doctors provides a simple mechanism of preventing any further dissatisfaction with the doctor. Nevertheless, it has the disadvantage that the doctor may not be aware that he has lost a patient and consequently, will not know the reasons for the patient's dissatisfaction.

No data is available to indicate how frequently this mechanism is used in Canada. A study by Warner suggests that it is infrequent. 17

In Great Britain, where general practitioners are paid on a capitation basis, records are maintained of each doctor's "panel" or list of patients. It is, therefore, possible to determine the frequency with which patients change doctors. This was documented by Klein in his book, Complaints against Doctors. His data indicated that approximately 1 in every 250 patients changes their doctor each year. 18 It should be noted that these figures specifically excluded changes due to changes in address. It might be expected that in Canada, where changing doctors does not involve a bureaucratic process, that the frequency of switching doctors may be greater than in the U.K.

5. Double-Checking

A mechanism of accountability of a similar nature to changing doctors is that of double-checking or visiting another doctor to verify the diagnosis of a previous doctor. Such double-checking has been frequently observed at The Hospital for Sick Children in Toronto, and is particularly noted in a clinic known as the "Drop-In Clinic", where no prior appointment is required. 19

It is not known how common this practice is in Canada. Wolfe and Badgely report that an unpublished study of the Saskatchewan Medical Care Insurance Commission found that "nearly 90% of users of care in a
given year saw only one doctor and the majority of the remainder were referred to others by the first doctor seen\(^{20}\).

6. Malpractice Litigation

The final and most extreme mechanism of accountability open to patients is medical malpractice litigation. As will become apparent later in this study, there are a number of difficulties in initiating a medical malpractice suit. It should be noted, however, that medical malpractice litigation provides the only mechanism by which the patient may receive reimbursement for any losses he may have incurred as a result of the doctor's actions. It is, therefore, unique amongst the other mechanisms of accountability.

Peer Directed Accountability

There are a number of mechanisms by which doctors may be held accountable by their peers. Although these are often initiated by individuals other than doctors (particularly by patients), the process is largely one of peer review.

1. Medical Referral Structure

Freidson in his essay on "Client Control and Medical Practice", notes that the position of the physician in the process of referrals may reflect on the degree of informal peer review to which the physician is subject:

"If he is the first practitioner seen in the lay referral structure, and if he sends no cases further on, he is subjected only to the lay evaluation of his patients... If he refers a case to another practitioner, however, his professional behaviour becomes subject to the evaluation of the consultant. In turn, when the patient leaves the consultant, he often..."
passes back to the referring practitioner so in this sense, the professional consultant is subjected to the evaluation of the referring physician".

Thus, the more involvement a physician has in the referral process, the more likely his work will be informally scrutinized and reviewed by colleagues. In the case of a consultant, the referring physician may censure his actions by not referring any further patients. The consultant, in contrast, may censure the referring physician by suggesting indirectly to the patient not to return to the referring physician.

2. Group Medical Practice

It has been suggested that one of the advantages of group medical practice is that it automatically forces a doctor to be accountable to his co-workers. Wolfe and Badgely describe the situation in a group practice in Saskatoon:

"The presence of co-workers in the Saskatoon Clinic not only contributed to the doctor's efficiency, but also caught them in a web of informal checks on their performance. For as well as peer review, their work was subject to constant scrutiny for its thoroughness by nurses, technicians and the medical staff...."

In most instances, such peer and co-worker accountability will be informal. In some group practices, a formal process of peer review has been instituted. Such a process, it has been reported, requires considerable commitment by the partners, if it is to be successful.

3. Hospitals

Since most practising physicians require privileges at a hospital, the hospital provides the third locus for peer accountability. Although
appointments to hospitals are controlled by the lay Board of Trustees, they generally accept the recommendation of the Medical Advisory Committee, a committee comprised almost entirely of doctors.

Accreditation standards in Canada require that hospitals institute formal mechanisms of medical audit. The generally accepted mechanism is that of criteria audit in which the actual handling of disease entities is compared with the hypothetical ideal situation. Such an audit does not reflect on an individual practitioner, but rather on the medical staff as a whole. Hospitals may introduce a variety of other mechanisms of accountability. These may include utilization review, tissue review, mortality rounds and discharge rounds. These mechanisms, to various degrees, hypothetically hold the individual doctor accountable to his peers.

Complaints referred to a hospital concerning a doctor would normally be received by the hospital's administrator. If the hospital is sufficiently large, these complaints would be referred for action to the chief of the medical department to which the doctor is appointed. Complaints of a serious nature may be reviewed by the M.A.C. whose recommendation concerning the continuation of the doctor's appointment would be sent to the hospital's Board of Trustees. In a recent case where a doctor walked out of the operating room in the middle of an operation when complications had developed, the Medical Advisory Committee of the hospital recommended severely curtailing his operating privileges. The Board of Trustees, however, felt that the circumstances demanded a more severe penalty and suspended the doctor's hospital appointment. This is an unusual situation where the Board over-ruled the M.A.C. and is
perhaps an indication that Trustees will be taking a more active role in quality control decisions in the future. Certainly, physician accountability within hospitals is becoming more pronounced as accreditation agencies demand increased medical audit and Trustees demand greater expression of accountability.

4. Provincial Licensing Agencies

A fourth locus of peer directed accountability is the provincial licensing agency. All provinces have established medical licensing agencies which are controlled by licensed physicians. All of these agencies have mechanisms of reviewing complaints concerning the professional conduct and behaviour of doctors licensed under their jurisdiction. A questionnaire (see Appendix B) was sent to each of these agencies requesting information on their complaint and disciplinary proceedings. After two mailings, eight of the ten agencies responded to the questionnaire.

Although the results of the questionnaire indicated that the details of each of the systems differ from province to province, they tended to follow the scheme outlined below.

Licensing of doctors is performed by an agency whose members consist of all individuals licensed by the agency. The agency is governed by a council or board, whose members are elected by the members of the agency. In several instances, there are a small number of lay (non medical) members appointed to the council by the Minister of Health of the province.

Verbal or written complaints may be received by the agency concerning a licensed doctor. All complaints are screened by the employees of the agency and attempts are made to resolve minor disputes at this level.
Unresolvable and major complaints (those of professional misconduct), are generally referred to a Complaints Committee. The Complaints Committee which may or may not have lay representatives, reviews the complaint and returns a decision concerning it. If the Complaints Committee feels that there is evidence of professional misconduct or incompetence, it will recommend that the complaint be taken to the Disciplinary Committee. The Disciplinary Committee will hold a hearing, decide whether there has been a breach of professional misconduct, and if so, assign a penalty ranging from a reprimand to a permanent suspension of license.

Variations occur in this process from province to province. In Newfoundland, the Registrar is given considerable discretion in the handling of complaints. In addition, Newfoundland has no separate complaint or disciplinary committee, but the Registrar refers all "serious" cases to the Medical Board, the governing body of the agency.

In Nova Scotia and New Brunswick, the complaints committee is known as the "Committee on Discipline". All written complaints are referred to this committee which may recommend to the Medical Board that the case be dismissed, the practitioner reprimanded or in situations of professional misconduct or mental instability, that an inquiry committee be appointed to take further action.

Doctors in Quebec are licensed under "The Professional Code" by which 38 other occupations are also licensed. Each occupation has its own "Corporation" whose governing body or "Bureau" is elected by the members or licencees of the corporation. The legislation requires that each corporation form a disciplinary committee whose chairman is a lawyer appointed by the Governor in Council. All complaints concerning a member
of the corporation must be sent to the Discipline Committee. The Discipline Committee acts as an administrative tribunal, and its decision may be appealed to the "Professions Tribunal" which is composed of 5 judges. The legislation also creates a central agency known as the "Office Des Professions Du Quebec". This agency is responsible for ensuring the "protection of the public" and as such acts as a watchdog agency over the corporation.

Ontario has not gone as far as Quebec, but has consolidated the licensing of five health related professions, Medicine, Dentistry, Optometry, Nursing and Pharmacy, under the Health Disciplines Act. Each profession is organized into a College and governed by a council which has lay representation in addition to the elected representatives. In the case of medicine, all written complaints concerning licensed physicians are first investigated by the College's staff and then referred to the Complaints Committee. Situations of apparent professional misconduct or incompetence are referred by the Complaints Committee to the Discipline Committee for a formal inquiry. In other situations, the Complaints Committee may dismiss the complaint or admonish the doctor if the Committee feels his behaviour was unprofessional but not professional misconduct. Situations of mental or physical incapacity are referred to the Executive Committee for further action. If a complaint is dismissed by the Complaints Committee, both the complainant and the doctor against whom the complaint was lodged, may appeal the decision to the Health Disciplines Board. This is a Board of 5 to 7 lay members appointed

*Although it may appear illogical for a doctor to appeal a dismissal of a complaint, several such appeals have been made when the dismissal included an admonishment.
by the Governor in Council. The purpose of the Board is to ensure that all complaints are handled fairly and as such the Board may over-rule the decision of the various Complaints Committee.

In Manitoba, the method of handling complaints follows fairly closely to the general scheme outlined previously. All complaints are reviewed by a Complaints Committee. Situations concerning standards of medical practice are referred to the Standards Committee for further review. Complaints concerning ethical or moral areas are referred to the Executive Committee which may or may not institute a formal inquiry (equivalent of a Discipline Committee).

The handling of complaints in Saskatchewan and Alberta follows the general scheme. In British Columbia, however, the Complaints Committee also carries out the responsibilities normally associated with Discipline Committees.

In most instances, the legislation and regulation concerning the licensing of the medical profession do not present a clear definition of "professional misconduct". The legislation in Saskatchewan lists 12 areas which constitute professional misconduct. The regulation in Ontario (see Appendix C) are more extensive and lists 31 areas ranging from "failure to maintain the standards of practice of the profession" to an incorrect listing in the telephone directory.

The biennial reports of the Ontario College outline the cases handled by the Disciplinary Committee over the previous 6 months. It was therefore possible to review the cases for the period June, 1973 to February, 1977. Table II outlines the results of this review.
Table II - Outline of Cases Handled by the Discipline Committee of the College of Physicians and Surgeons of Ontario for the Period of June, 1973 to February, 1977

<table>
<thead>
<tr>
<th>Nature of the Charge</th>
<th>Total</th>
<th>Convictions</th>
<th>Dismissals</th>
</tr>
</thead>
<tbody>
<tr>
<td>conflict of interest</td>
<td>9</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>standard of practice</td>
<td>22</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>billing irregularities</td>
<td>13</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>sexual relationship with a patient</td>
<td>7</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>other</td>
<td>15</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>66</td>
<td>37</td>
<td>29</td>
</tr>
</tbody>
</table>

Although "failure to conform to the standards of practice of the profession" was the most frequent charge, only 27% of these cases resulted in a conviction. Ethical problems (sexual relations with a patient, conflict of interest, etc.) although less frequent, resulted in a higher conviction rate. This data would therefore suggest that the profession has some difficulty in either defining acceptable standards of practice or judging whether these standards have been met.

Included in this questionnaire to the licensing agencies was a request for data indicating the number of complaints received and how these complaints were handled. Several agencies were unable to supply any data and in others, the data was incomplete. Overall, the data available was inadequate for making inferences or for comparing the situation between jurisdiction.

A final question asked of the licensing agents was whether they review all cases of medical malpractice to determine whether disciplinary
actions should be taken. Only Quebec indicated a positive reply noting that "L'Infomation Judiciare" and "La Semaine Commerciale" lists every lawsuit in the Province of Quebec. It should be noted that similar case reviews are available in other areas of the country.

The overall impression of the licensing agencies in Canada is that they attempt to serve the interest of the public while also serving the interests of the profession. Ontario and Quebec have recognized the potential conflict between these goals and have attempted to provide safeguards to ensure that the interests of the profession do not over-ride those of the public. Quebec’s safeguard is an agency which acts as a watchdog over all licensed professions. In addition, they have attempted to ensure equity in the handling of complaints by appointing a judge to be chairman of the Discipline Committee and by setting up a process of appeal of decisions of this Committee. The emphasis in Ontario has been to protect the rights of the individual by ensuring access to the complaints handling machinery. In addition, through appeal to a lay board, equity in the handling of complaints is assured. In other provinces, access and equity in the handling of complaints is less certain due to the lack of an appeal mechanism for the complainant. In conclusion, it is interesting to note that of the six responding provincial licensing agencies (other than Quebec and Ontario), none of them anticipated changes in the legislation governing their operation in the near future.

Social Accountability

As with all members of society, doctors are expected to conform to the social norms outlined in society's laws. In the last section, it was
indicated that the provincial legislatures have largely allocated the responsibility for the setting and enforcing of medical standards to medical licensing agencies. Exceptions do exist; for example, the inclusion of regulations concerning abortion in federal criminal law. It is interesting to note that other responsibilities which would normally be handled by civil authorities, have been allocated to licensing bodies. In Ontario, for example, the investigation of billing abnormalities by doctors is handled by a Committee of the College of Physicians and Surgeons of Ontario. This Committee is then able to recommend to OHIP, the provincial health insurance plan, whether the billing was legitimate or whether payment should be withheld. In normal circumstances, such investigations would be handled by the police and prosecutions handled through the courts.

Much of the responsibility for the social accountability of individual medical practitioners has been placed in the hands of the profession by the provincial legislatures. It is clearly in the best interests of the profession not to significantly abuse these powers since the legislature can just as easily remove them. Legislative control, therefore, provides assurances against the significant abuse of the powers by the profession of medicine.

A second mechanism of social accountability is medical malpractice litigation. In contrast to the process of peer review of the medical licensing agencies, medical malpractice suits are judged according to the standards and values of society rather than those of the profession of medicine. In many cases, the standards and values of society and those of medicine are equivalent. Nevertheless, situations have occurred where the courts have over-ruled the accepted professional standards. Medical
malpractice litigation, therefore, provides a process of social accountability, not only for the individual practitioner, but also for the profession of medicine.

**Conclusion**

This chapter has presented an outline of mechanisms by which both the practitioner and the profession may be held accountable. Medical malpractice litigation provides one of these mechanisms and is notable in that it may be classified as a process of social accountability. In addition, medical malpractice litigation provides the only mechanism whereby the patient may receive reimbursement for losses incurred as a result of medical treatment.


5. IBID, p. 53.


FOOTNOTES - CHAPTER II

15. Interview with Dr. Bernard Dickens, Visiting Professor, Faculty of Law, University of Toronto, Toronto, June, 1977.


19. Interview with Dr. Donald Stewart, Director, Medical Out-patient Department, Hospital for Sick Children, Toronto, July, 1976.


27. Saskatchewan, Medical Profession Act, Revised Statutes of Saskatchewan 1965, Cap 303.


30. For Example, Dominion Reports, Ontario Reports, Etc.


CHAPTER III

THE PURPOSE AND FUNCTIONS OF MEDICAL MALPRACTICE LITIGATION

As a process of law, medical malpractice litigation may be seen as having intended social functions or purposes. In turn, it may directly or indirectly serve unintended social functions. It is therefore necessary to examine the social roles, both intended and unintended, of medical malpractice litigation.

Medical malpractice litigation is one of many actions which is handled through the law of torts. It will therefore be useful to briefly examine the nature and purpose of the law of torts.

The Nature, Purpose and Function of the Law of Torts

The law of torts is a section of common law: that is law based primarily on past precedents rather than on legislated statutes. It is consequently an area of law which is in a constant state of flux as the acceptability of past precedents and new judgements is constantly being tested. The process of litigation provides the vehicle for this testing and the end product of litigation, the judgement, identifies the relevant precedent as well as indicating whether past precedents remain acceptable.

Wright, in his text on the law of torts, describes the purpose of this branch of common law as follows:

"Arising out of the various and ever increasing clashes of the activities of persons living in
a common society, carrying on business in com-
petition with fellow members of that society,
owning property which may in any of a thousand
ways affect the person or property of others -
in short, doing all the things which constitute
modern living - there must, of necessity, be
losses or injuries of many kinds sustained by
one person as a result of the conduct of
others. The purpose of the law of torts is
to adjust these losses and to afford compen-
sation for injuries sustained by one person
as the result of the conduct of others".*(1)

The law of torts, therefore, serves the role of assigning the respon-
sibility for the cost of losses and injuries. As such, it provides a
mechanism by which compensation may be obtained. However, as Wright and
Linden later point out, "no system of law will ever attempt to compensate
for all losses".² According to what criteria then, are losses viewed as
being acceptable for compensation by the courts?

Not surprisingly, these criteria have changed significantly over
the last three centuries as the law of torts has adapted to the con-
tingencies of new social and technological developments. Fleming has
suggested three stages in the development of the law of torts.³

The first, prior to the Industrial Revolution, saw cases of tort
judged on the basis of whether the defendant had intentionally caused the
trespass harm or damage. Unintentional trespass, harm or damage was
generally assessed in favour of the defendant.⁴

With the development of the Industrial Revolution in the late 18th
and early 19th centuries, people's activities became more inter-related
and with urbanization, contact between people became more frequent. As
a consequence, the opportunity for the sustaining of losses and injuries
as a result of another's activity, became more frequent. It was during
the 19th century that the postulate "no liability without fault" became
the accepted legal doctrine in the law of torts. This was achieved by requiring the plaintiff to prove that his misfortune was the result of intentional or negligent misconduct by the defendant. The use of "fault" was believed to serve the additional function of providing a deterrent to the behaviour "at fault", since the consequences, more often than not, were financial ruin. It should also be noted that the use of the term "fault" carried with it (as it still does), a moral connotation of blameworthiness. The second stage of the development of law of torts, therefore, was that period when "fault" was the prime criteria by which tort judgements were made.

Up until the end of the 19th century, the law of torts was seen as having a "cost shifting" function in that losses were transferred from one individual or enterprise to another. By the beginning of the 20th century, however, it was finally recognized that many enterprises were treating the cost of tort liability as overheads to be absorbed in the price of the goods or services being produced. In this instance, the impact of tort judgements was one of "cost spreading" of losses amongst consumers rather than one of "cost shifting". The introduction, and now almost universal application of liability insurance, has further emphasized the "cost spreading" rather than "cost shifting" effect of tort judgements.

Liability insurance has also had profound effects on the administration of the law of torts so that it has been suggested that the postulate "liability without fault" is fast becoming the norm. Factors most responsible for this trend include the tendency for insurance companies to settle claims out of court frequently with little regard to the issues
of negligence and fault; government intervention in several liability fields, most notably workmen's compensation and automobile insurance, and the tendency of courts (particularly juries), to sympathetically favour that party with the least ability to spread the cost of the loss (usually the plaintiff). The overall impact has been the erosion of the authority of the doctrine of "no liability without fault". In certain fields, this erosion is almost complete, for example, with worker's compensation schemes (universal in Canada), where tort recovery by litigation against an employer has been abolished in return for lower but assured benefits of workmen's compensation. Another example is the introduction, in several jurisdictions, of "no fault" automobile insurance.

The third stage in the development of the law of torts has been marked, therefore, by the increased utilization of "cost spreading" mechanisms (i.e. insurance) so that the impact of tort judgements has been towards the "cost spreading" rather than the cost shifting" of losses. This has been accompanied by the gradual erosion of fault as the criteria of loss allocation. It should be noted that these changes are currently in process and are by no means complete. In certain areas, fault still remains a strong determinant of loss allocation. In addition, "cost spreading" has not completely replaced the "cost shifting" effect of tort judgements.

The primary purpose of the law of torts, therefore, remains the assignment of the responsibility for carrying the cost of losses and injuries. As such, the law of torts provides a mechanism whereby compensation for losses may be obtained. Although the erosion of "fault" and the increasing incidence of
"cost spreading" has lessened the impact of tort judgements on the individual, the law of torts continues to serve a number of unintended social functions. These include the setting of acceptable standards of behaviour as well as the deterrence of behaviour judged by the courts as being unacceptable.

The Nature and Purpose of Medical Malpractice Litigation

Where does medical malpractice litigation fit into this scheme of the law of torts? Surprisingly, it is one of the fields of the law of torts in Canada where "fault" rules supreme. The reasons are several.

In the first place, the overwhelming majority of practising doctors in Canada do not carry medical malpractice insurance. Protection against medical malpractice litigation is generally obtained through membership in the Canadian Medical Protective Association (C.M.P.A.). Although the C.M.P.A. has never failed to cover the cost (including awards of litigation brought against its members, it is not strictly liable for these costs and hence is not an insurer. Originally modelled after the medical defence unions in Great Britain, the C.M.P.A. endeavours to protect the reputation of its members and the profession of medicine in Canada. Towards this end, the C.M.P.A. will provide, regardless of cost, a comprehensive defence for its members against malpractice claims it considers unjust, harassing or frivolous. In claims where a doctor is considered clearly at fault, a reasonable settlement will be attempted out of court; however, if there is any chance that the doctor was not a fault, the C.M.P.A. will defend and appeal his case up to the Supreme Court. Such a policy clearly maintains the primacy
of fault in determining whether the defendant should carry the losses. This may be compared to the situation in the U.S. where insurance carriers will frequently settle minor claims without regard to their validity in order to avoid costly court proceedings.¹⁵

A second factor which has maintained the primacy of "fault" in Canadian medical malpractice litigation is the general practice in Canada, of disallowing judgement by jury.¹⁶ The exclusion of juries is based on the belief that the technical nature of evidence is beyond the comprehension of most individuals and that consequently, a fair judgement would not be reached. This effectively prevents the tactic frequently used in the U.S.A. of swaying the jury by appealing to their sympathies.¹⁷

A final factor is the general policy of Canadian courts not to accept the dictum of "res ipsa loquitur" (the thing speaks for itself) in medical malpractice cases.¹⁸ Under this dictum, obvious injuries are considered obvious cases of fault, and the defendant is then responsible for showing that he was not "at fault". This partial transfer of the "burden of proof" from the plaintiff to the defendant reduces the impact of fault since fault is assumed until it is disproved.

What then, is the social purpose of medical malpractice litigation in Canada? As with all tort actions, medical malpractice litigation serves the purpose of assigning the responsibility of covering the cost of losses and damages which in this case, have been incurred as a result of a doctor's professional activities. As such, it provides patients with a mechanism by which they may obtain compensation for medically caused injuries and losses.
Other Functions served by Medical Malpractice Litigation

As a process of law, medical malpractice litigation may be ascribed certain intended functions or purposes. In turn, it may be seen as having certain unintended effects. These include:

1. Defining Unacceptable Standards of the Practice of Medicine

By ascribing "fault" and consequently, the responsibility for carrying the costs of medically caused injuries and losses, the courts are in effect, censuring the behaviour of the doctor as being socially unacceptable. The rulings of the court, therefore, define both acceptable and unacceptable standards of practice of medicine.

2. Deterrence of Negligent Conduct

Roemer contends that "there is no question that the threat of malpractice suit is an inducement to elevate the diligence of medical performance". Such elevation of diligence, no doubt, serves a positive role up to a certain point. Beyond that point, however, it has possible negative effect. It has been argued that doctors in the U.S.A., under the increasing pressure of medical malpractice litigation, are steering away from procedures known to be "suit prone", even when these procedures are indicated. Additionally, it has been suggested that the same pressure is causing doctors to order unnecessary diagnostic tests in an effort
37

to protect themselves from litigation. 21

3. Quality Control over the Practice of Medicine

Freidson describes the current system of quality control in most jurisdictions as follows:

"Traditional management of the problem of assuring an adequate standard of medical care consists of recruiting intellectually capable students, training them properly before licensing them, and then turning them loose to practice. Such management rests on untennable assumptions about the stability, strength of motives, values and knowledge absorbed within the course of a limited period of formal education". 22

In Chapter II, it was indicated that licensing agencies have the machinery for determining and censuring unacceptable standards of practice. The results of a review of the disciplinary proceedings of the College of Physicians and Surgeons of Ontario, suggested that difficulties were encountered in either defining acceptable standards of practice or judging whether these standards have been met.

Although it has been asserted that "the malpractice action may be ignored in any realistic assessment of the adequacy of existing quality control", it has played an important role in unearthing deficient practices in medicine, in initiating and promoting new practices (i.e. sponge counts), and in defining minimal acceptable standards of quality.

4. Social Accountability of the Individual Practitioner and Profession of Medicine

As was discussed in Chapter I, both the individual practitioner and the profession of medicine have acquired considerable power over the patient and over the practice of medicine respectively. In Chapter II, the various mechanisms of accountability were presented and discussed. Medical malpractice litigation is notable in this respect in that it is a mechanism
of social accountability rather than peer accountability. In addition, it provides the patient with a mechanism of compensation for medically caused injuries and losses.

Conclusions

The role of medical malpractice litigation as a mechanism of medical accountability is secondary to its prime purpose of assigning the responsibility for carrying the costs of injuries and losses resulting from medical treatment. Medical accountability is, in fact, one of several positive effects resulting from this judicial compensation mechanism. Other effects include the deterrence of socially unacceptable modes of practice, and quality control over the practice of medicine.
FOOTNOTES - CHAPTER III


4. IBID, p. 4.

5. IBID, p. 7.


7. IBID, p. 9.

8. IBID, p. 16.

9. IBID, p. 22.

10. IBID, p. 16.

11. It has been suggested by Calabresi: that the purpose of all Accident Law, including Tort Law, should be the minimization of Accident Costs. His theories are examined in Chapter VII. Guido Calabresi, The Costs of Accidents, (New Haven: Yale University Press, 1970).

12. In 1972 the Canadian Medical Protective Association provided protection against malpractice litigation for 89% of the doctors in Canada. See Chapter V for details.


14. IBID.


FOOTNOTES - CHAPTER III


CHAPTER IV

MEDICAL MALPRACTICE DEFINED

The determination of whether a doctor's behaviour constitutes medical malpractice belongs to the courts. A review of the basis upon which such judgements are made, will outline the court's current position with respect to medical malpractice.

Formal court proceedings are instituted by the plaintiff with the issue of a "writ of summons". The writ must include a concise summary of the plaintiff's claims and "causes of action" known as "endorsement". "Cause of action" has been defined by the courts as "every fact that is material to be proved to entitle the plaintiff to succeed".

Due to the long experience of common law, "causes of action" tend to fall into well defined areas. In the case of the law of torts, these areas include trespass to person (i.e. assault, battery), negligence, trespass to land, nuisance, defamation, etc. Each area is affected by certain statutes (e.g. limitation periods) and governed by the precedents pertaining to that area. The statement of the "cause of action" will therefore determine the criteria by which the claim will be judged. It may also influence the basis by which damages, if any, may be awarded.

The "cause of action" of medical malpractice claims against doctors tends to fall under two areas: negligence and trespass to person.

In this section, the procedures and standards of the court in its
judgement of what behaviour constitutes medical malpractice, will be discussed. For this purpose, the areas of "negligence" and "assault and battery" will be treated separately. Each section will commence with an outline of the general legal considerations of that area of the law followed by an examination of its application in cases of medical malpractice.

Negligence

Every form of activity carries with it the possibility of harm to others. The assignment of liability for that harm is indicative that society views the risks of that activity as being unreasonable. The continuation of that activity in the light of its unreasonable risks is negligence.

1. Standard of Care

The difficulty facing the law is the determination of the point at which risks become unreasonable and activities consequently negligent. It is a problem of balancing "the gravity of the risk created" against "the social utility of the conduct involved". As such, it is a subjective judgement and consequently, subject to differences of opinion.

The law has attempted to solve this problem by resorting to the model of the "reasonable man of ordinary prudence". The reasonable man of ordinary prudence is "the embodiment of all the qualities which we demand of the good citizen: and if not a model of perfection, yet altogether a rather better man than probably any single one of us happens or perhaps even aspires to be". This model, therefore, is the
standard to which all individuals are required to conform. Negligence in this context has been defined as:

"the omission to do something which a reasonable man guided upon the considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent and reasonable man would not do".

Over time, the courts have made certain qualifications to this model. For example, children are not expected to conform to this standard, although behaviour by adults is not excused on account of lack of personal experience and knowledge. Qualifications to this model in the area of medical negligence will be discussed later in the chapter.

2. The Elements of Negligence

The courts have evolved a number of artificial techniques or elements by which the issues in a negligence claim are elucidated and decided. These elements are:

(a) the establishment that a duty existed by the defendant towards the plaintiff;

(b) the establishment that a breach of that duty occurred by the defendant.

(c) the establishment that material injury occurred to the interests of the plaintiff;

(d) a proof of causation that the material injury to the plaintiff was the result of the breach of duty by the defendant.

(a) The Issue of Duty

"A man is entitled to be as negligent as he pleases to the whole world if he owes no duty to them".

The above quotation serves to emphasize the difficulty in determining under what circumstances a duty of care exists. The classical pronouncement of a general formula for duty is Justice Atkin's "neighbour test"
in Donoghue vs. Stevenson:

"There must be, and is, some general conception of relations giving rise to a duty of care, of which the particular cases found in the books are but instances....The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyers question, Who is my neighbour? receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law, is my neighbour? The answer seems to be - persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question".11

This test is of limited utility, however, since it requires a value judgement concerning the foreseeability of events. As Fleming declares:

"recognition of duty of care is the outcome of a value judgement, that the plaintiff's invaded interest is deemed worthy of legal protection against negligent interference by conduct of the kind alleged against the defendant. In the decision, whether or not there is a duty, many factors interplay: the hand of history, our ideas of morals and justice, the convenience of administering the rule and our social ideas as to where the loss should fall".12

It is notable that a breach of the duty of care towards one individual cannot be used as grounds for a claim by another individual. The legal duty of the defendant, to take care, must be owed to the plaintiff.13

(b) The Issue of Breach of Duty

The issue of breach of duty is closely related to the establishment of the existence of a duty. Breach of duty may be the result of acts or omissions. Early common law only recognized acts of affirmative misconduct as grounds for compensation for injuries.14 Inaction was viewed as being too remote a focus for imposing legal responsibility. This doctrine is slowly being revised as the court recognizes omission of action as grounds
for negligence. However, in the absence of some existing duty, there is no obligation for an individual to act. For example, where a plaintiff is endangered by a source quite unconnected with the defendant, the latter has no obligation to come to his assistance. 15

(c) The Issue of Material Injury

In the absence of material injury, the plaintiff has no grounds for damages in spite of the negligence of the defendant. The difficulty facing the courts has been the determination of what constitutes material injury. They have tended to only accept situations of obvious physical injury as financial loss. More recently, however, less apparent injuries such as mental anguish or nervous shock found acceptance as evidence of material injury. 16

(d) The Issue of Causation

The issue of causation, commonly known as "remoteness of damage" or "proximate cause" presents considerable problems to the court. The difficulty lies in determining whether the breach of duty or negligence by the defendant was responsible for the material injury to the plaintiff.

Unlike a scientific proof, where hypotheses are tested through the results of numerous trials, legal proof of causation is concerned only with the case at hand: whether in this particular case the evidence indicates that the activities of the defendant resulted in the material injury to the plaintiff. Scientific proof, therefore, is of limited utility in the determination of causation in a negligence case.

The commonly utilized test of causation is known as causa sine qua non or the "but for" test. 17 "The formula postulates that the defendant's
fault is a cause of the plaintiff's harm if such harm would not have occurred without (but for) it. Conversely, it is not a cause if the harm would have happened just the same, fault or no fault". The "but for" test clearly does not reduce the degree of supposition of causation frequently required in negligence cases. It does, however, provide a focus for elucidating the issue of causation.

The establishment that the defendant's negligence was a causal factor in the plaintiff's injury, does not necessarily lead to full legal liability.

The courts have been moving in the direction of ascribing liability only for damages which could have been foreseen. The issue of foreseeability, however, necessitates a value judgement which makes consistency in awarding damages impossible.

3. Burden of Proof

As previously mentioned, it is the responsibility of the plaintiff to prove negligence, not the responsibility of the defendant to disprove it. Since the defendant may be the only individual able to show the true cause of the accident, the plaintiff may face extreme hardship in proving his case. The principle of res ipsa loquitur (the thing speaks for itself) assists in dispelling this hardship. Under this principle, the plaintiff must first show that "the thing...is under the management of the defendant" and that "the accident is such as in the ordinary course of things, does not happen if those who have the management use the proper care". When these two factors have been established, the plaintiff is entitled to have the case submitted for judgement. The defendant is then
In this respect is that of determining in Roe and Wolley vs. Ministry of
in the handling of claims of medical negligence. A notable observation
It has frequently been conceded that special care should be taken
to medical malpractice will be presented in this section.
if handling the issue of negligence. The application of this approach
The above section outlines the general approach of the legal system

The Negligent Doctor

By legislation pertaining to specific categories of negligence.
In generally, the period of limitation; however, may be modified

The limitation period throughout Canada for the Tort of negligence

other evidence tends to disappear. 2

extrinsically become less credible,
and the recollection of such witnesses in
Great extent upon the testimony of witnesses

Justice then justice in it.
though that a stale claim may have more than
been found liable to pay damages. It is action
defendant indefinitely to the possibility of

This limitation as follows:
may be commenced. Williams outlines the traditional justicication for
all Canadian jurisdiction limit the time in which a tort action

4. Limitation of action

sheltered from the plaintiff to the defendant.
causing the accident. In other words, the burden of proof is partially
responsible for persuading the jury that he was in no way negligent in

47
"It is so easy to be wise after the event and to condemn as negligence that which was only misadventure. We ought always to be on guard against it especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way. Something goes wrong and shows up a weakness and then it is put right".

He later concluded his judgement with these words:

"But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that appears to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only misadventure".

These statements have since been quoted in numerous judgements in Canada, and in a sense, they have set the tone for the courts' approach to claims for medical malpractice. The tone has been one of conservatism in which the doctor's liability has been contained rather than expanded as in the U.S.A.

1. **Standard of Care**

Chief Justice Tindal in 1838 articulated the following principle which survives to this day:

"Every person who enters a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you will gain your cause;"
nor does a surgeon undertake that he will perform a cure; nor does he undertake to use higher education and greater advantages than he has, but he undertakes to bring a fair, reasonable, and competent degree of skill.\textsuperscript{25}

The medical practitioner, therefore, is obligated to exercise "a reasonable degree of care and skill". Schroeder in a frequently quoted judgement of the Ontario Court of Appeal, was more specific when he asserted:

"He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing...."\textsuperscript{26}

The model of the "reasonable man of ordinary prudence" gives way to the model of the "reasonable practitioner of ordinary prudence", the type of practitioner being determined by the defendant's qualifications. Specialists are therefore expected to perform at a level consistent with their specialty; a level higher than the general practitioner. This principle was enunciated by Mr. Justice Schroeder as follows:

"...if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability".\textsuperscript{27}

Thus

"The surgeon, by his ordinary engagement with the patient undertakes...(to possess) the skills, knowledge and judgement of the generality, or average of the special group or class of technicians to which he belongs and...(to) faithfully exercise them".\textsuperscript{28}

Although a specialist is expected to maintain a higher standard of care than a general practitioner, he is not expected to achieve perfection. Thus, a dermatologist escapes responsibility if the procedure he adopts is in "accordance with generally accepted good medical practice in the field of dermatology".\textsuperscript{29} In turn, no liability ensues if an unsuccessful
operation is conducted in a way "consistent with good orthopedic surgical practice".30

The above two examples are indicative of the strength placed by the courts in the standard of "custom" or "common practice" in medical malpractice cases. As Linden indicates:

"Understandably, evidence of general practice is accorded more respect in medical matters than it receives in other types of cases, because there is greater judicial trust in the reasonableness of a sister profession than there is in the methods of commercial men. Further, in the professional cases, the contractual undertaking made is only to employ customary treatment methods".31

A defence against medical negligence, based on customary professional practice, however, is not conclusive.32 The courts have recognized that in the final outcome, they, not the profession of medicine, are responsible for determining acceptable standards of medical care.33 Nevertheless, customary practice remains the doctor's surest defence and it only in exceptional circumstances, where the practice is clearly improper, that the courts rule against it.

The so-called "locality rule" although generally disliked has not been completely rejected by the courts. The rule provides that a doctor must "merely live up to the standard of the profession in his own community or similar localities".34 Chief Justice Falconbridge criticised the "locality rule" as long ago as 1902 on the grounds that:

"all the men practising in a given locality might be equally ignorant and behind the times and regard must be had to the present advanced state of the profession and to the easy means of communication with, and access to, the large centres of education and science...."35

In effect, the locality rule has created dual standards of care with
rural areas subject to a lower standard than urban areas. Linden contends
that the difference between urban and rural areas is no longer one of
"standard of care" but one of "access to facilities and equipment". An allowance should be made for this difference, but not one which creates
a double standard for Canadian doctors bases on geography.

The issue of whether a doctor is obliged to consult a specialist if
a reasonably prudent doctor would consider it necessary, is still questionable. In one notable case, a doctor failed to call in a specialist, despite the
urgings of his patient, since he felt such action was premature. The
action was dismissed even though the judge had indicated that "most medi-
cal men would have" called in a specialist. Linden contends that:

"Because specialists are more numerous these days, general practitioners tend to rely upon them more than ever. Liability should follow if a doctor
fails to call in a specialist when a prudent practitioner would deem it advisable".

In conclusion, the medical practitioner is required to exercise a reasonable degree of care and skill so that he performs up to the standard
of care of the average practitioner of his specialty. In general, but not always, conformity to the customary practices of the profession is
proof of maintenance of this standard of care.

2. Elements of Medical Negligence

As with all negligence, the plaintiff in a medical negligence suit
must establish that his material injury was a result of the defendant's
breach of duty. The issues of "duty", "breach of duty", "material injury"
and "causation" deserve to be examined in relation to medical negligence.

(a) The Issue of Duty

A doctor owes no duty to a potential patient until a doctor/patient
relationship has been established. This relationship may be extremely easy to form as in the case when a doctor approaches an accident victim. Nevertheless, a doctor is under no legal duty to accept a particular person as a patient even if he has treated that individual in a previous but unconnected illness.

Once a doctor/patient relationship has been established, however, the doctor is obliged to continue treating the patient as long as the case requires attention. This obligation may be terminated by a joint agreement limiting the duration of service, by the patient discharging the doctor or by the doctor voluntarily withdrawing from the case. In the latter situation, the doctor must give the patient reasonable notice to enable him to secure alternative treatment.

(b) The Issue of Breach of Duty

In all negligence claims, the plaintiff must establish that a breach of duty occurred by the defendant. The plaintiff in a medical negligence suit must therefore show that the defendants did not conform to or surpass acceptable standards of medical care. These standards have been briefly reviewed in the previous section "Standard of Care".

The difficulty facing the plaintiff, is to prove in unmistakable terms that the doctor's actions were substandard. With the court's strong dependence on the standard of customary practice, this proof generally requires the assistance and co-operation of medical witnesses. Although in recent years, doctors in Canada have shown a greater willingness to assist litigants in a malpractice action, most doctors are exceedingly hesitant to condemn the action of one of their colleagues. The litigant, therefore, may have to depend on the testimony of the defendant's medical
witnesses to establish that the defendant deviated from the accepted standard of care.

(c) The Issue of Material Injury

No matter how negligent a doctor may have been, a patient will lose his case unless he can establish to the courts, satisfaction that damage or loss has occurred. Although traditionally, only direct physical damage was considered evidence of material injury, less apparent injuries such as mental anguish have recently been accepted.

(d) The Issue of Causation

The establishment that the defendant's breach of duty resulted in the plaintiff's material loss can present considerable difficulties in a medical malpractice suit.

The complex nature of medical treatment where numerous factors and influences are in operation, makes the definitive determination of cause/effect relationships difficult at the best of times. This is compounded by the fact that medicine is still as much an art as a science.

As with the establishment of a breach of duty, the establishment of causation usually requires expert testimony from medical witnesses. The difficulty in obtaining sympathetic medical witnesses again adds to the difficulty in establishing fault by the plaintiff.

3. Burden of Proof

From the previous discussion, it is obvious that in many medical malpractice cases, it is impossible to establish direct evidence of fault. The alternative open to the plaintiff is to invoke the doctrine of res
ipsa loquitur (the thing speaks for itself).

In the past, it was believed that this principle did not apply to medical malpractice actions. Although more recently the rule has been applied, it is still the exception rather than the rule. As recently as 1974, Ritchie declared that:

"It appears to me that in medical cases where differences in expert opinion are not unusual and the sequence of events often appears to have brought about a result which has never occurred in exactly the same way before to the knowledge of the most experienced doctors, great caution should be exercised to ensure that the rule embodied in the maxim res ipsa loquitur is not to be construed so as to place too heavy a burden on the defendant. Each such case must of necessity, be determined according to its own facts and it seems to me that the rule should never be applied in such cases by treating the facts of one case as controlling the result in another, however, similar those facts may be".

Even in cases where the rule has been invoked, often little benefit has accrued to the plaintiff for according to Schroeder:

"when the rule applies, its effect is to shift the onus to the defendant but...broadly speaking, in such cases, where the defendant produces an explanation equally consistent with negligence and no negligance, the burden of establishing negligence still remains with the plaintiff".

4. Limitation of Action

In 1887, a section of the Ontario Medical Act was amended so that:

"no duly registered member of the College of Physicians & Surgeons of Ontario, shall be liable in any action for negligence or malpractice, by reason of professional services requested or rendered, unless such action be commenced within one year from the date when in the matter complained of such professional services terminated".

Subsequently, all other provinces in Canada adopted this or a similar
limitation provision. 48

The above provision severely limits the patient in the pursuit of a claim. Sharpe, in his review of the limitation period in medical malpractice cases, cites many justified cases which were rejected due to the period of limitation running out. 49 The classic case is where a doctor, in performing an operation, leaves a foreign object, such as a surgical swab within the body. Frequently, the presence of this object is not discovered until after the period of limitation has been passed. 50

In 1974, the limitation period for malpractice actions in Ontario was revised with the assent of the Health Disciplines Act. This act now declares that:

"No duly registered member of a College is liable to any actions arising out of negligence or malpractice in respect of professional services requested or rendered unless such action is commenced within one year from the date when the person commencing the action knew or ought to have known the fact or facts upon which he alleges negligence or malpractice". 51

This change provides a greater opportunity to the plaintiff to pursue his or her claim. The determination of the date of commencement of the limitation period, however, promises to present great difficulties to the court. It is notable that the provision applies not only to the patient but to "the person commencing the action".

Trespass to the the Person

The action of trespass to the person is known under the heading of "assault and battery".

Assault consists of "intentionally creating in another person an
The apprehension of imminent harmful or offensive contact.  The intent to do violence must be expressed in threatening acts, not merely in threatening speech. Even threatening acts do not constitute an assault unless they are of such a nature to put the plaintiff in fear or apprehension of immediate violence.

"The application of force to the person of another without lawful justification amounts to the wrong of battery." It does not matter with what force the contact was made and judgements have been made for spitting in another man's face, cutting his hair or kissing a woman.  Contact conforming with accepted usages of daily life are no cause for complaint unless they are conducted in a hostile manner or it is recognized that they would be resented by the plaintiff.

Assault may either be intentional or unintentional. In the latter case, it must be proved that the unintentional contact was the result of negligence by the defendant.

The most frequent defence to a claim for assault and battery is consent. The contends that "no wrong is done to one who consents" — volenti non fit injuria. Consent may be given expressly, as when a patient authorizes a surgeon to perform an operation, or implied as in the case of participation in sporting games or simply walking in a crowd.

Medical Trespass to the Person

Clearly, any action by the doctor in handling the patient could be construed as "battery". A justifiable cause, or a consent for the action of the doctor in touching the patient is therefore required.

The voluntary presence of a patient in a doctor's office or hospital
implies a consent to relatively minor procedures. As Rozovsky points out, "if there were no damages and the touching of the patient was minor and part of the general treatment, it is probable that an assault action would not be taken, or that it would be thrown out of court as an abuse of the court's process". More complex procedures, however, should require a consent. In fact, in several Canadian provinces, it is a regulation of the Public Hospital Act or similar legislation that no surgical operation shall be performed on a patient unless a consent in writing for the performance of the operation has been signed by the patient or his guardian. The signing of a written consent, however, is not necessarily valid since it is the circumstances in which consent was obtained, rather than the consent itself which is important. Rozovsky defines five criteria which must be met if a consent is to be legally valid.

1. **Voluntary Consent**

   The consent must be given voluntarily under such conditions that the patient feels free to either consent or refuse as he so wishes. A consent obtained under conditions of compulsion, duress, or fraudulent misrepresentation, is invalid.

2. **Informed Consent**

   The patient must be aware of the nature and implications of the procedure for which he is consenting. Canadian courts, unlike those in the U.S., have not defined strict rules for informing the patient but require that the information be honest. There is no necessity for a physician to explain in detail the actual medical techniques being used
as long as the nature of the treatment is fully understood. It should be noted that informed consent, in effect, transfers the responsibility for decision making and consequently, the responsibility for risk taking from the doctor to the patient. Failure to adequately inform the patient of the possibility of an unsuccessful or injurious outcome places an increasing liability on the physician. In the U.S.A. this failure is increasingly being treated under the cause of action of negligence (i.e. breach of duty of care, leading patient to accept harmful treatment he would have declined if he had been adequately informed) rather than the cause of action of assault and battery.

3. Consent to Act Performed

The nature of treatment should follow as closely as possible to the consent given. This does not prevent the doctor from exercising his professional judgement after the consent has been made. In non-emergency situations, however, additional consent should be obtained if there is a radical departure from the proposed mode of treatment.

4. Consent to a Particular Person Touching

A consent implies that a particular individual has been given permission to handle the patient. In cases where no assurance can be made that some other person may handle the patient, the patient should be informed of this fact.

5. Capable of Consent

The patient must have the legal capacity to consent. He must be of sufficient age to be classified an adult. Although the age of majority has been considered the age at which individuals are capable of consenting,
many provinces have adjusted this age in the case of medical treatment (i.e. in Ontario, it is 16 years of age). Additionally, the courts have recognized consents of minors who are emancipated from their parents.

Patients under psychiatric care who are considered unsound of mind present difficulties when consent for treatment is required. As Rozovsky points out:

"Public trustees are not usually given power over the person of a patient but over his estate only. Thus, consent cannot be given by this official. Similarly, mental health legislation usually does not give the director or administrator of a mental hospital the power of guardianship over the person of his patient".  

Since guardianship proceedings are frequently costly, consent is usually obtained from relatives and hospital administrators.

In cases of emergency, when the patient is unable to consent due to his or her condition, consent is not required. The doctor must show, however, that "it was not possible to obtain the patient's consent and that the procedure was immediately necessary to preserve the health and life of the patient".

Conclusions

In Canada, medical malpractice claims have been pursued through the causes of action of "negligence" and "assault and battery".

A doctor is considered negligent if he fails to exercise on behalf of his patient a reasonable degree of care and skill as could be expected of a normal prudent practitioner of the same experience and standing. Before a judgement of negligence can be made, however, the plaintiff must show that:

(a) a doctor/patient relationship existed;
(b) that the patient suffered some material injury as a result of the doctor's substandard care and skill; and

(c) the period of limitation of action has not been exceeded.

The plaintiff faces some difficulties in pursuing his or her claim since the doctrine of *res ipsa loquitur* is seldom invoked in medical malpractice cases. In addition, the plaintiff may have difficulty obtaining expert medical witnesses to support his or her case.

In a medical malpractice case, "assault and battery" has occurred if the doctor touches a patient without obtaining his or her consent. In order for a consent to be valid, it must be informed and given voluntarily by an individual capable of consenting.

There are clearly advantages to following the cause of "assault and battery" as compared to "negligence". In "assault and battery", fault does not have to be shown nor is it necessary for any material injury to have befallen the plaintiff.

2. IBID, p. 3.

3. Taylor V. Reid, (1906), 130 L.R. 205.


5. IBID, p. 107.

6. IBID.


9. IBID, p. 104.


13. IBID, p. 139.

14. IBID, p. 140.

15. IBID, p. 141.


18. IBID.

19. IBID, p. 190.


23. IBID, p. 86.


27. IBID.


34. Linden, "The Negligent Doctor," p. 36.


40. IBID, p. 189.

41. IBID.

42. IBID.

43. IBID.


FOOTNOTES - CHAPTER IV

46. IBID.


49. IBID, p. 145.


53. IBID, p. 23.

54. IBID.

55. IBID.

56. IBID, p. 77.


60. IBID,


63. IBID, p. 112.
CHAPTER V

THE PROCESS AND EXTENT OF MEDICAL MALPRACTICE LITIGATION IN CANADA

In this chapter, an examination will be made of the process of medical malpractice litigation. In addition, past trends in the amount and cost of litigation will be presented.

The Process of Medical Malpractice Litigation

Every doctor-patient encounter has the potential to develop into a medical malpractice suit or claim. The fact that this occurs infrequently (see analysis on Page), is indicative that barriers exist to malpractice actions. It would be hoped that the most significant barrier is that the patient is satisfied or has no complaint concerning his encounter with the doctor. In fact, it would be hoped that the patient both feels and actually has benefited from the encounter.

1. The Process - An Overview

Figure II is an expansion of the flow chart of the process of medical accountability (presented in Chapter I) with a specific focus on medical malpractice litigation. It presents an outline of the basic decision making process by which medical malpractice suits develop. Although it does not present every possible permutation in development of a malpractice claim, it does outline all the major decisions which lead toward litigation. It consequently presents a useful tool for examining the process of medical malpractice litigation. Of particular
Figure 2 - Flow Chart of the Process of a Medical Malpractice Suit.

Start

Doctor Patient Encounter

No

Patient Dissatisfied with Encounter?

Yes

Patient Takes Action?

No

Stop 1

Yes

Stop 2

Patient Takes Action Other Than Litigation?

Yes

Other Action

No

Patient Consults Lawyer?

No

Stop 3

Stop 5

No

Lawyer Advises Further Action?

Yes

Yes

Patient Takes Lawyer's Advice?

Yes

Commence Legal Action

No

Stop 4

Stop 6

No

No

Yes

Patient Takes Lawyer's Advice?
Figure 2 (continued).

1. Patient and Counsel Contact Doctor

Patient and Counsel seek Compensation

Doctor Accepts Liability?

Yes

Doctor Makes Settlement Offer

No

Stop 8

Yes

Patient Accepts Offer?

No

No

No

Patient Takes Claim to Court?

Yes

Stop 7

No

Patient Seeks Out of Court Settlement?

Yes

No

Patient and Counsel Take Claim to Court?

Yes

No

No

Court Proceedings

No

Stop 9

Yes

Doctor Makes Higher Settlement Offer?

No

Court Proceedings

Yes

Doctor Accepts Liability?

No

Court Rewards Damages

No

Stop 11

Yes

Court Finds Doctor LIABLE?

No

Stop 10
interest are the points where the action ceases (where the flow chart indicates "STOP"). It will be useful to examine each of these points and hypothesize the possible causes for the cessation of action.

**STOP 1**

The action commences with the doctor-patient encounter. As was discussed in Chapter II, if the patient is to take further action, he must be dissatisfied with some aspect of the encounter. Cessation of action at STOP 1 is indicative of patient satisfaction. It should be noted that patient satisfaction may be unfounded, and the patient may have been harmed by the encounter; however, if the patient is satisfied, it is unlikely that he will take further action.

**STOP 2**

If the patient has been dissatisfied with the encounter, he must now decide whether to take further action. Failure to take further action may be based on temporal considerations in that the individual is unwilling to spend time pursuing the matter. On the other hand, the individual may be ignorant of the possible channels of action open to him.

**STOP 3**

If an individual is aware that mechanisms exist for resolving his dissatisfaction, he may pursue these mechanisms. In Chapter II, these various mechanisms were presented and discussed. The action ceases at STOP 3, therefore, when satisfaction is obtained through one of the alternative mechanisms of medical accountability presented in Chapter II.

**STOP 4**

If the patient remains dissatisfied, he may choose to take his case
to a lawyer. He may, however, be unaware that legal recourse is available or feel intimidated by the legal structure and choose not to consult a lawyer. Finally, the potential financial expense may deter him from taking legal action.

**STOPS 5 & 6**

The patient consults a lawyer and depending on the facts of the case, the lawyer may recommend continuing or ceasing further action. Clearly, the lawyer will recommend no further action if the case has no legal justification. In addition, the lawyer will probably inform the client of the likely financial cost of further action. On the basis of the above arguments, the patient may choose to follow or disregard the lawyer's recommendation. Consequently, lack of legal justification and financial cost may be responsible for STOP 5 and 6.

**STOP 7**

If the patient decides to take legal action, he or his legal representative will request compensation from the doctor. The doctor will probably have legal counsel which in most cases, would be provided by the Canadian Medical Protective Association. If the doctor does not admit liability and refuses to negotiate a settlement, the patient must decide whether or not to take his claim to court. The reasons for deciding against further action at this time would either be financial or lack of legal justification.

**STOPS 8 & 9**

If the doctor accepts liability, he will make a settlement offer. This may be accepted by the patient or negotiations may occur until a mutually agreeable settlement is reached. STOP 8 is the point at which
such a settlement is reached.

If the patient is dissatisfied with and refuses to accept the doctor's final settlement offer, he must decide whether or not to commence court proceedings. The patient may have misgivings about the cost of further legal proceedings and decide not to take the case to court. In this case, he will probably again seek a settlement offer from the doctor. In the unlikely event that he does not seek a final agreement for settlement, STOP 9 occurs.

STOPS 10 & 11

Court proceedings may develop either because the doctor refuses to assume responsibility for the patient's loss or because the doctor's settlement offer falls below the patient's expectations. Once court proceedings have commenced, an out of court settlement may still be agreed upon.

At the end of the court proceedings, the court rules either in favour of the patient (the plaintiff) or the doctor (the defendant). In the former case, the court awards damages (including court costs), and in the latter case, the case is dismissed and with the court costs of the defendant generally being charged to the plaintiff.

2. Review of Barriers

The above discussion has suggested that the following barriers to medical malpractice litigation exist:

i. patient satisfaction;
ii. temporal cost;
iii. lack of knowledge and confidence with the legal system;
iv. satisfaction by alternate mechanism;
v. financial cost;
vii. lack of legal justification;
vii. settlement achieved.

(i) Patient Satisfaction

Although on the surface, patient satisfaction appears to be an acceptable outcome to a doctor/patient encounter, this may not be altogether true. In the ideal outcome, not only should the patient be satisfied, but he should have been handled with competence and should have received treatment as his condition required. Clearly, the situation may occur where the patient is satisfied but has been handled incompetently and has suffered as a result.\(^2\) In general, this may be due to the patient failing to realize that his suffering resulted from incompetent treatment. In addition, the doctor-patient relationship may serve to hide this incompetence.

As individuals become more knowledgeable in medical science, and as the profession or medicine gradually loses its mystique, it may be expected that more individuals will recognize when they have been treated incompetently.

(ii) Temporal Cost

Clearly, the continuation of any action requires a temporal commitment. If such a commitment does not exist, it could be argued that the case is not sufficiently important to the litigant to require further action. On the other hand, the acceptance of a temporal cost could prove to be an excessive burden to the litigant. In general, this barrier can only be viewed as an unfortunate but inevitable barrier to litigation.
(iii) Lack of Knowledge of and Confidence in the System

The average Canadian's understanding of the legal system is minimal. This ignorance serves to reduce the alternatives open to the average individual in the resolution of disputes. In addition, the legal system often appears intimidating to the layman, and this may deter him from seeking legal recourse.

If the legal system is removed from the ordinary Canadian, quasi legal alternatives may seem equally remote. For example, many individuals are probably unaware that recourse concerning a doctor's actions may be obtained through the provincial licensing authorities.

It has been suggested that students should be taught an understanding of the legal system while attending high school. This would certainly assist in reducing the current remoteness of this important social institution.

(iv) Satisfaction Through Alternate Mechanisms

In Chapter II, a number of mechanisms of physician accountability were presented and discussed under the title of "medical accountability system". These mechanisms provide the dissatisfied patient with alternatives to litigation in the resolution of his dissatisfaction.

(v) Financial Cost

In Canada, the cost of litigation may be debilitating. In the first instance, the client must hire and cover the expenses of a lawyer. If the individual is unsuccessful in the lawsuit, it is likely that the "costs of court" of his opponent will be levied against him. The potential cost therefore, is considerable.

In the case of medical malpractice litigation, the risk of loss of
suit, and consequently, the financial risk is probably greater than for most other areas of litigation. The fact that most doctors in Canada provide malpractice protection through the Canadian Medical Protective Association (C.M.P.A.), is responsible for this increased risk.

As noted earlier, the C.M.P.A. is an organization formed by doctors to provide protection to individual doctors and to the profession as a whole against "unwarranted, unjust, and excessive claims of medical malpractice". The C.M.P.A. is not an insurance company; it is a protective association. As a consequence, if it feels a claim is unjust, excessive, harassing or frivolous, it will fight that claim, regardless of cost, as far as the Supreme Court. This philosophy, coupled with the policy of the courts to assign the "costs of court" to the losing party, gives the C.M.P.A. a great deal of leverage when bargaining with the patient or litigant.

The legal aid system which is administered by each province, provides financial support for individuals with a very low income. In general, legal aid in Canada is viewed as inadequate. Not only does it benefit a very small group, its actual benefits are generally substandard and do not attract the most experienced lawyers.

It is probably the middle classes who have most difficulty in financially supporting a medical malpractice claim. Without strong financial support, the risk of losing the case may appear frightening. On the other hand, they are ineligible for legal aid. In the U.S., the contingency fee system has provided some relief although it has notable drawbacks. Under a contingency fee system the client agrees to pay his lawyer a percentage of any award gained. In return, the client pays the
lawyer no fees even if the case is lost. In Canada, seven of the ten provinces permit contingency fees. In all cases, the percentage of fees allowed is limited to a certain percentage of the award. It has been suggested that professional ethics have discouraged the use of contingency fees in Canada. There is, however, the more cynical viewpoint that their lack of use is based on their unprofitability.  

(vi) Lack of Legal Justification

Chapter IV reviewed the criteria and standards by which the court judges medical malpractice. In cases of alleged negligence, the plaintiff must establish that a duty of care existed, that there was a breach of this duty, and that this breach of duty resulted in material injury to the plaintiff. If the plaintiff is unable to prove the above, it is likely that he will be unsuccessful. In turn, in cases of "trespass to person", the plaintiff must be able to show that there was no consent or that the consent obtained was invalid. The emphasis in both cases is that the plaintiff must be able to prove that negligence or trespass occurred. Clearly, he may have a legitimate case, but if he is unable to prove his case to the satisfaction of the court, then he will probably be unsuccessful.

As was mentioned in Chapter VI, proving a case of medical malpractice may be exceedingly difficult. With respect to negligence, establishment of a breach of duty and establishment of causation may be particularly troublesome due to the complex nature of medical treatment and the difficulty in obtaining a sympathetic expert medical witness. In addition, unlike other areas of negligence, medical malpractice suits are rarely afforded relief in the burden of proof through the invocation of the doctrine
Another notable disadvantage to the litigant is the usual disallowance of trial by jury in medical malpractice suits. This effectively removes the usually more sympathetic judgement of "12 men strong and true". Finally, the statute of limitations which in many provinces limits the commencement of medical malpractice suit to within 1 or 2 years of the date when the professional services terminated, has disallowed a number of apparently legitimate claims.

There are, therefore, a number of difficulties facing a potential litigant in developing a legally justified claim.

(vii) Settlement Achieved

The achievement of a settlement before or during court action is the legitimate result of bargaining between the litigant and the defendant. Such a result may, on the surface, appear to be ideal. However, the settlement will probably reflect the differing power of the two bargaining parties. Earlier in the chapter, it was noted that the policy of the C.M.P.A. to pursue claims it considers unjust, harassing or excessive, coupled with the potentially high cost of pursuing (and particularly losing) a malpractice claim, places the C.M.P.A. in a strong bargaining position. It is consequently likely that the C.M.P.A. has been able to obtain favourable settlements.

Conclusions Concerning the Process of Medical Malpractice Litigation

The above analysis suggests that there are a number of significant barriers to medical malpractice litigation. Barriers such as "patient
satisfaction" and "satisfaction by alternate mechanisms" would probably be viewed as socially acceptable. "Settlement achieved" may also be viewed as acceptable although the power of the C.M.P.A. may produce a settlement which does not do justice to the claims of the litigant.

It might be assumed that "lack of legal justification" would be an acceptable barrier. Nevertheless, the system in Canada appears to favour the doctor as evidenced by the generally short period of limitation, the general disallowance of trial by jury, and the doctrine of "res ipsa loquitur" in malpractice cases, and the difficulty the plaintiff has obtaining sympathetic expert witnesses. Individually, each of these factors may be seen as giving the court a minor tendency to favour the doctor. In combination, however, their effect may be additive, thereby producing a strong orientation in favour of the doctor. As a U.S. study of medical malpractice litigation in Canada suggests, the Canadian system "psychologically favours the doctor". 7

The barriers of "financial cost" and "lack of knowledge and confidence with the legal system" would probably be viewed as unacceptable. As mentioned previously, the actual costs of litigation and the potential costs of losing the case are considerable. These costs are multiplied by the policy of the C.M.P.A. to pursue to the highest possible level, all claims it considers unjust. There can be no doubt that actual and potential financial costs provide a strong incentive against suing the doctor.

"Lack of knowledge and confidence in the legal system" is an unfortunate byproduct of Canadians' lack of contact with the legal system. In the U.S.A, where every child's education includes a close review of the
constitution, citizens are generally aware of their considerable rights, and the fact that these rights may be protected through court action. Although Canada has a Bill of Rights, it has proven to be a rather ineffectual document, and therefore, does not provide the same focus on the legal system as the constitution in the United States.

"Satisfaction by alternative mechanism" provides an acceptable and useful barrier to litigation. Often patients only wish to ensure that what has happened to them, will not occur in the future. Alternate mechanisms may often achieve this or a similar goal (see Chapter II).

Overall, the process of medical malpractice litigation in Canada appears to be overly restrictive to the patient or plaintiff. As a consequence, litigation does not provide an accessible mechanism for obtaining compensation for losses and injuries resulting from medical treatment.

The Extent and Cost of Medical Malpractice Litigation in Canada

Most doctors in Canada provide protection for themselves against medical malpractice litigation through membership in the Canadian Medical Protective Association (C.M.P.A.). The percentage of physicians in Canada covered by the C.M.P.A. has gradually increased from 69% in 1961, to 89% in 1972.

1. The Extent of Medical Malpractice Litigation in Canada

Table III presents a graphical outline of the annual volume of new claims made against members of the C.M.P.A. since 1960. Prior to 1960,

* estimate.
the amount of litigation was relatively insignificant, and in most years less than 10 new claims were made. In the decade of the sixties, there was a gradual increase in new claims so that by the end of the decade, 60 or more new claims were being made annually. The early seventies saw this rate of increase accelerate and in 1974, over two hundred new claims were made. From 1961 to 1975, there was an overall 816% increase in new claims. 668% or 4/5ths of that increase occurred from 1970 to 1975.

It would be expected that the amount of litigation each year would roughly reflect the number of services or doctor-patient encounters during that year. Unfortunately, this data is not available. Data on the number of doctors covered by the C.M.P.A., however, is available and Table IV presents a histogram of new claims per 1,000 doctors at risk for the years 1961-1975. The histogram suggests that the number of doctors at risk may explain a portion of the increase in claims particularly for the 1961-1970 period. During this period, the number of claims per year increased by 220% whereas the increase in new claims per 1,000 doctors was only 89%.

Table V outlines the percentage increase in new claims each year which is unexplained by the increase in doctors at risk (Column C). Column A shows the percentage increase in new claims over the previous year. Column B, the percentage in new claims each year explained by the increased number of doctors at risk, is subtracted from Column A to give Column C. The mean unexplained increase each year is 7%. After examining Table IV, it might be suspected that the largest part of this increase has occurred in the years 1971-75. The hypothesis that "the percentage annual increase in new claims has been significantly higher in the 1970-75
Table IV - New Claims per 1000 Doctors at Risk, 1961-1975.
Table V - The Percentage Increase in New Claims Each Year that is Unexplained by the Increase in the Number of Doctors at Risk, 1961-1975

<table>
<thead>
<tr>
<th>YEAR</th>
<th>A*</th>
<th>B**</th>
<th>C*** = A-B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>56.3%</td>
<td>47.7%</td>
<td>8.6%</td>
</tr>
<tr>
<td>1962</td>
<td>36.0</td>
<td>29.4</td>
<td>6.6</td>
</tr>
<tr>
<td>1963</td>
<td>5.9</td>
<td>2.9</td>
<td>3.0</td>
</tr>
<tr>
<td>1964</td>
<td>36.1</td>
<td>29.4</td>
<td>6.7</td>
</tr>
<tr>
<td>1965</td>
<td>0</td>
<td>-7.6</td>
<td>7.6</td>
</tr>
<tr>
<td>1966</td>
<td>14.3</td>
<td>5.5</td>
<td>8.8</td>
</tr>
<tr>
<td>1967</td>
<td>14.3</td>
<td>8.1</td>
<td>6.2</td>
</tr>
<tr>
<td>1968</td>
<td>1.6</td>
<td>-7.1</td>
<td>8.7</td>
</tr>
<tr>
<td>1969</td>
<td>-4.6</td>
<td>-10.5</td>
<td>5.9</td>
</tr>
<tr>
<td>1970</td>
<td>29.0</td>
<td>25.0</td>
<td>4.0</td>
</tr>
<tr>
<td>1971</td>
<td>63.8</td>
<td>51.8</td>
<td>12.0</td>
</tr>
<tr>
<td>1972</td>
<td>16.0</td>
<td>10.2</td>
<td>5.8</td>
</tr>
<tr>
<td>1973</td>
<td>10.5</td>
<td>3.7</td>
<td>6.8</td>
</tr>
<tr>
<td>1974</td>
<td>31.0</td>
<td>19.7</td>
<td>11.3</td>
</tr>
<tr>
<td>1975</td>
<td>4.0</td>
<td>0.9</td>
<td>3.1</td>
</tr>
<tr>
<td>Mean</td>
<td>20.9%</td>
<td>13.9%</td>
<td>7.0%</td>
</tr>
</tbody>
</table>

* A: percentage increase in new claims over previous year  
** B: percentage increase in new claims/1,000 doctors over previous year  
*** C=A-B: percentage increase in new claims per year that is unexplained by the number of doctors at risk
period than in the 1961-1970 period," was consequently tested. At a 90% level of significance ($t \leq 1.771$) a $t$ test ($t = 1.29$) indicated that there was no significant difference between these time periods. This allows the suggestion that if trends in new claims continue as they have in the past, then an average of 7% increase in claims would be expected if the number of doctors at risk remains static. Table VI outlines the expected volume of new claims as well as the number of claims per 1,000 doctors up until 1990. In 1990, one in every 47 doctors would have a claim made against him. This compares to one in every 131 doctors in 1975. If the future follows the trends of the last 15 years, it may be expected that there will be a notable increase in the volume of new claims.

Table VI—Projected Annual Number of New Claims and New Claims per 1,000 Doctors, 1975-1990

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PROJECTED NEW CLAIMS</th>
<th>PROJECTED NEW CLAIMS PER 1,000 DOCTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>229</td>
<td>7.63</td>
</tr>
<tr>
<td>1976</td>
<td>245</td>
<td>8.16</td>
</tr>
<tr>
<td>1977</td>
<td>262</td>
<td>8.73</td>
</tr>
<tr>
<td>1978</td>
<td>280</td>
<td>9.33</td>
</tr>
<tr>
<td>1979</td>
<td>300</td>
<td>9.93</td>
</tr>
<tr>
<td>1980</td>
<td>321</td>
<td>10.69</td>
</tr>
<tr>
<td>1981</td>
<td>344</td>
<td>11.46</td>
</tr>
<tr>
<td>1982</td>
<td>368</td>
<td>12.26</td>
</tr>
<tr>
<td>1983</td>
<td>394</td>
<td>13.12</td>
</tr>
<tr>
<td>1984</td>
<td>426</td>
<td>14.19</td>
</tr>
<tr>
<td>1985</td>
<td>456</td>
<td>15.19</td>
</tr>
<tr>
<td>1986</td>
<td>488</td>
<td>16.25</td>
</tr>
<tr>
<td>1987</td>
<td>522</td>
<td>17.39</td>
</tr>
<tr>
<td>1988</td>
<td>559</td>
<td>18.62</td>
</tr>
<tr>
<td>1989</td>
<td>598</td>
<td>19.92</td>
</tr>
<tr>
<td>1990</td>
<td>640</td>
<td>21.32</td>
</tr>
</tbody>
</table>
2. The Costs of Medical Malpractice Litigation in Canada

Table VII presents the total costs of the C.M.P.A. during the years 1961-1975.

Table VII - Total Costs of the Canadian Medical Protective Association, 1961-1975

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TOTAL COSTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>$ 122,325</td>
</tr>
<tr>
<td>1962</td>
<td>166,165</td>
</tr>
<tr>
<td>1963</td>
<td>133,744</td>
</tr>
<tr>
<td>1964</td>
<td>112,137</td>
</tr>
<tr>
<td>1965</td>
<td>161,920</td>
</tr>
<tr>
<td>1966</td>
<td>328,806</td>
</tr>
<tr>
<td>1967</td>
<td>309,954</td>
</tr>
<tr>
<td>1968</td>
<td>427,356</td>
</tr>
<tr>
<td>1969</td>
<td>403,861</td>
</tr>
<tr>
<td>1970</td>
<td>812,261</td>
</tr>
<tr>
<td>1971</td>
<td>687,255</td>
</tr>
<tr>
<td>1972</td>
<td>747,204</td>
</tr>
<tr>
<td>1973</td>
<td>993,176</td>
</tr>
<tr>
<td>1974</td>
<td>1,077,434</td>
</tr>
<tr>
<td>1975</td>
<td>$1,952,466</td>
</tr>
</tbody>
</table>

(Source: Annual General Reports, 1961-1975, Canadian Medical Protective Association, Ottawa)

There has clearly been an increase in the total costs of the C.M.P.A. over this period as the costs of 1975 were 1,500% greater than the costs of 1961. On average, the annual increase in costs over the previous year has been 28%. The period of the late 1960's and early 1970's proved to be one of high inflation and consequently, inflation may be partially responsible for these increased costs. Table VII presents total costs converted to 1961 dollars using the Consumer Price Index.
Table VIII - Total Costs of the C.M.P.A. in 1961 Dollars, 1961-1975

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TOTAL COSTS (1961 $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>122,325</td>
</tr>
<tr>
<td>1962</td>
<td>164,195</td>
</tr>
<tr>
<td>1963</td>
<td>129,849</td>
</tr>
<tr>
<td>1964</td>
<td>107,001</td>
</tr>
<tr>
<td>1965</td>
<td>150,764</td>
</tr>
<tr>
<td>1966</td>
<td>295,158</td>
</tr>
<tr>
<td>1967</td>
<td>268,590</td>
</tr>
<tr>
<td>1968</td>
<td>355,829</td>
</tr>
<tr>
<td>1969</td>
<td>321,802</td>
</tr>
<tr>
<td>1970</td>
<td>626,261</td>
</tr>
<tr>
<td>1971</td>
<td>515,184</td>
</tr>
<tr>
<td>1972</td>
<td>544,481</td>
</tr>
<tr>
<td>1973</td>
<td>660,356</td>
</tr>
<tr>
<td>1974</td>
<td>645,944</td>
</tr>
<tr>
<td>1975</td>
<td>1,056,529</td>
</tr>
</tbody>
</table>

Using these revised figures, total costs still increased a substantial 764% over the 15-year period.

It would be expected that costs would increase with the number of claims handled by the C.M.P.A. Exact numbers of claims handled annually by the C.M.P.A. are not available; however, an approximation of these numbers is possible by combining the number of new legal actions or claims with the number of claims dismissed, discontinued, settled or lost. Table IX outlines the average yearly cost per claim in process (in 1961 dollars). Over the 15-year period, the average annual cost per claim in process has been $2,643 (1961 dollars). This figure has remained relatively stable as indicated by the median or $2,643 and range of
Table IX - Average Cost, in 1961 Dollars per Claim in Process, 1961-1975

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TOTAL COSTS (1961 $)</th>
<th>CLAIMS IN PROCESS</th>
<th>COST/CLAIM IN PROCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>$ 122,325</td>
<td>45</td>
<td>$2,718</td>
</tr>
<tr>
<td>1962</td>
<td>164,195</td>
<td>53</td>
<td>3,098</td>
</tr>
<tr>
<td>1963</td>
<td>129,849</td>
<td>58</td>
<td>2,239</td>
</tr>
<tr>
<td>1964</td>
<td>107,001</td>
<td>72</td>
<td>1,486</td>
</tr>
<tr>
<td>1965</td>
<td>150,764</td>
<td>81</td>
<td>1,861</td>
</tr>
<tr>
<td>1966</td>
<td>295,158</td>
<td>101</td>
<td>2,922</td>
</tr>
<tr>
<td>1967</td>
<td>268,590</td>
<td>111</td>
<td>2,420</td>
</tr>
<tr>
<td>1968</td>
<td>355,829</td>
<td>112</td>
<td>3,177</td>
</tr>
<tr>
<td>1969</td>
<td>321,802</td>
<td>102</td>
<td>3,155</td>
</tr>
<tr>
<td>1970</td>
<td>626,261</td>
<td>144</td>
<td>4,349</td>
</tr>
<tr>
<td>1971</td>
<td>515,184</td>
<td>208</td>
<td>2,477</td>
</tr>
<tr>
<td>1972</td>
<td>544,481</td>
<td>215</td>
<td>2,532</td>
</tr>
<tr>
<td>1973</td>
<td>660,356</td>
<td>246</td>
<td>2,684</td>
</tr>
<tr>
<td>1974</td>
<td>645,944</td>
<td>347</td>
<td>1,862</td>
</tr>
<tr>
<td>1975</td>
<td>1,056,529</td>
<td>396</td>
<td>2,668</td>
</tr>
</tbody>
</table>

Mean $2,643

$1,486 - $4,349. It therefore appears that the increase in costs may be explained by both the increase in claims and the inflation rate.

The C.M.P.A. classifies its expenses into three categories: awards or settlements, legal costs and administrative costs. Table X outlines this breakdown for the years 1961-1975.
Table X - Breakdown of Total Costs of the Canadian Medical Protective Association, 1961-1975

<table>
<thead>
<tr>
<th>Year</th>
<th>Settlement and Award Costs</th>
<th>% Total</th>
<th>Legal Costs</th>
<th>% Total</th>
<th>Admin. Costs</th>
<th>% Total</th>
<th>Total Costs</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>70,222</td>
<td>42.3</td>
<td>39,174</td>
<td>23.6</td>
<td>56,769</td>
<td>34.1</td>
<td>166,165</td>
<td>100.0</td>
</tr>
<tr>
<td>1962</td>
<td>30,609</td>
<td>22.9</td>
<td>35,945</td>
<td>26.9</td>
<td>67,190</td>
<td>50.2</td>
<td>133,744</td>
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</tr>
<tr>
<td>1963</td>
<td>16,478</td>
<td>14.7</td>
<td>21,716</td>
<td>19.4</td>
<td>73,943</td>
<td>65.9</td>
<td>112,137</td>
<td>100.0</td>
</tr>
<tr>
<td>1964</td>
<td>25,607</td>
<td>15.8</td>
<td>49,666</td>
<td>30.7</td>
<td>86,647</td>
<td>53.5</td>
<td>161,920</td>
<td>100.0</td>
</tr>
<tr>
<td>1965</td>
<td>168,119</td>
<td>51.1</td>
<td>67,553</td>
<td>20.6</td>
<td>93,134</td>
<td>28.3</td>
<td>328,806</td>
<td>100.0</td>
</tr>
<tr>
<td>1966</td>
<td>132,137</td>
<td>42.6</td>
<td>72,158</td>
<td>23.3</td>
<td>105,659</td>
<td>35.1</td>
<td>309,954</td>
<td>100.0</td>
</tr>
<tr>
<td>1967</td>
<td>154,812</td>
<td>36.2</td>
<td>151,384</td>
<td>35.4</td>
<td>121,340</td>
<td>28.4</td>
<td>427,356</td>
<td>100.0</td>
</tr>
<tr>
<td>1968</td>
<td>122,819</td>
<td>30.4</td>
<td>139,055</td>
<td>34.4</td>
<td>141,987</td>
<td>35.2</td>
<td>403,861</td>
<td>100.0</td>
</tr>
<tr>
<td>1969</td>
<td>439,247</td>
<td>54.1</td>
<td>221,771</td>
<td>27.3</td>
<td>151,243</td>
<td>18.6</td>
<td>812,261</td>
<td>100.0</td>
</tr>
<tr>
<td>1970</td>
<td>223,951</td>
<td>32.6</td>
<td>238,818</td>
<td>34.8</td>
<td>224,486</td>
<td>32.6</td>
<td>687,255</td>
<td>100.0</td>
</tr>
<tr>
<td>1971</td>
<td>276,292</td>
<td>37.0</td>
<td>251,924</td>
<td>33.7</td>
<td>218,988</td>
<td>29.3</td>
<td>747,204</td>
<td>100.0</td>
</tr>
<tr>
<td>1972</td>
<td>253,371</td>
<td>25.5</td>
<td>427,250</td>
<td>43.0</td>
<td>312,555</td>
<td>31.5</td>
<td>993,176</td>
<td>100.0</td>
</tr>
<tr>
<td>1973</td>
<td>325,087</td>
<td>30.2</td>
<td>441,662</td>
<td>41.0</td>
<td>310,685</td>
<td>28.8</td>
<td>1,077,434</td>
<td>100.0</td>
</tr>
<tr>
<td>1974</td>
<td>896,858</td>
<td>45.9</td>
<td>664,116</td>
<td>34.0</td>
<td>391,492</td>
<td>20.1</td>
<td>1,952,466</td>
<td>100.0</td>
</tr>
<tr>
<td>1975</td>
<td>951,609</td>
<td>43.1</td>
<td>766,916</td>
<td>34.8</td>
<td>487,282</td>
<td>22.1</td>
<td>2,205,807</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Annual Reports, 1961-1975, Canadian Medical Protective Association, Ottawa

On average, 35% of the total expenses of the C.M.P.A. are for settlements or awards. The remaining 65% of costs are in the areas of legal costs (31%) and administrative costs (34%). Settlement and award costs are therefore only a small portion of the costs of the C.M.P.A. It appears that the policy of the C.M.P.A. to fight any claim it considers unjust,
harrassing and excessive, may contribute to the high percentage of overhead costs of the C.M.P.A.

3. Conclusions Concerning the Extent and Cost of Medical Malpractice Litigation

The above analysis suggests that there has been a real increase of approximately 7% per year in the amount of litigation against doctors in Canada. This increase in claims has also been responsible for increasing the costs of the C.M.P.A. in handling claims. A second factor affecting costs has been inflation.

If the number of claims continues to increase at the current rate, by 1990, over 20 new claims per thousand doctors will be registered. This compares to a current rate of almost 8 claims per thousand doctors. With the high overhead costs of the C.M.P.A., this increase in claims will result in considerable increases in costs regardless of whether the claim is won or lost by the C.M.P.A.
1. Patient satisfaction may be unfounded, being based on misconception and incomplete information.

2. The reverse situation in which a patient has been treated competently, but nevertheless is dissatisfied, also exists.

3. The author presents himself as a typical example of a Canadian who, before this study, had virtually no understanding of the legal system.


6. Suggested by Dr. Bernard Dickens, Visiting Professor, Faculty of Law, University of Toronto in a seminar to the Department of Health Administration, Faculty of Medicine, University of Toronto, November, 1976.


8. Russell notes when speaking of the Supreme Court of Canada that "The Canadian Bill of Rights imposed a mammoth legislative task on any court which would take it seriously... it is no surprise that the Supreme Court of Canada responded reluctantly and unevenly to this challenge... Most of the judges, to put it mildly, do not seem anxious to assume the strong political role entailed in enforcing the standards of a comprehensive Bill of Rights on the popular Branch of Government. P.H.: Russell, "The Political Role of the Supreme Court of Canada in: It's First Century," Canadian Bar Review 53:576-593, 1975, p. 592.

9. Personal communication with Dr. R. Wales, Assistant Deputy Registrar, College of Physicians and Surgeons of Ontario.

10. Obtained using figures on the total number of Physicians in Canada, supplied by Statistics Canada.
CHAPTER VI

ALTERNATIVES TO MEDICAL MALPRACTICE LITIGATION

Illich has commented on what he views as the growing incidence of iatrogenic or medically-caused disease. It has been suggested that as medical care has become more sophisticated and medical treatment more powerful, the risk of harmful side effects from this care and treatment have also increased. For example, it has been well established that the risk of side effects from drugs increases exponentially with the number of concurrently administered drugs. Another notable example is the use of cardiac catheterization, an extremely risky procedure, in the diagnosis (not treatment) of cardiovascular and heart diseases.

Whether or not the incidence of iatrogenesis is increasing is a mute point and has not, as yet, been established. It has nevertheless been documented that one in every fifty children admitted to a hospital suffers an accident which requires specific treatment, and it has been estimated that this ratio may be as high as one in every five patients in adult research hospitals. Finally, the United States Department of Health Education and Welfare has calculated that 7% of all patients suffer compensatable injuries while hospitalized.

It is difficult, if not impossible, to compare the personal cost of these accidents with the cost of non treatment. Conceivably and hopefully, the risks and costs of iatrogenic disease are less than those of non treatment. Nevertheless, it is clear that both the personal and
social costs of medical accidents, whether caused by negligence or misadventure, are considerable and that the needs for a mechanism of compensation are great.

Medical malpractice litigation provides the only mechanism by which patients may obtain compensation for medically caused losses and injuries.\(^7\) It is a mechanism of selective compensation since only those cases where negligence or trespass to person can be shown, are compensated. Finally, access to medical malpractice litigation may be limited. As a result, medical malpractice litigation may be seen as a relatively ineffective mechanism of compensation.

It will be useful at this point to review a concept developed by Calabresi concerning accident cost reduction.\(^8\) This concept also happens to provide a useful framework for developing alternatives to medical malpractice litigation.

**Accident Cost Reduction**

Calabresi contends that the function of all accident law (including tort law) is to reduce "the sum of the costs of accidents and the costs of avoiding accidents".\(^9\) He suggests three subgoals to the above function.\(^10\)

(1) the goal of reducing the number and severity of accidents (primary accident costs);

(2) the goal of reducing the costs resulting from accidents (secondary accident costs), and

(3) the goal of reducing the costs of administering the handling or prevention of accidents (tertiary accident costs).

Calabresi notes that the above goals are not mutually exclusive but work in combination. For example, primary costs cannot be reduced beyond a certain point without incurring greater tertiary costs. The
function of accident law, he suggests, should be to balance these goals and thereby produce the lowest possible costs to society.

It will be useful at this point, to individually review each of these subgoals, outline mechanisms by which they may be achieved, and relate these goals to medically caused accidents. Due to the relationship between each of the goals, examining them individually may be somewhat artificial, but it will produce a useful result.

(1) Reducing Primary Accident Costs

The only means of reducing the primary costs of accidents is to reduce the number and severity of accidents. At first glance, we might suppose that the complete elimination of accidents would be the ideal situation. Such a goal, however, would be simplistic since every activity carries with it the risk of accidents. Consequently, the only certain way of eliminating all accidents would be to eliminate all activities. This is hardly a workable proposition.

Accidents are a risk of living. How then, can society reduce the number and severity of accidents whilst maintaining an acceptable level of activity? Calabresi suggests two possible approaches: the general or market deterrence approach\(^{11}\) and the specific or collective deterrence approach.\(^{12}\)

(a) General or Market Deterrence

This approach is based on the proposition that individuals know what is best for themselves and consequently, should be given the freedom to choose whether or not to engage in an activity given the direct and potential costs involved. General deterrence consequently, implies that accident costs should be included as one of the many costs of undertaking an activity. Each individual would then be forced to consider accident
costs in choosing among activities, and the sum of these choices would produce the best possible combination of activities.

General deterrence is essentially based on the economic theory of resource allocation. Although this theory, in its pure form, is somewhat questionable, it may provide a useful tool if modified. Calabresi suggests modifying the basic tenet that "individuals sometimes know what is best for themselves". The implication is that in certain but not all activities, general deterrence may be a useful tool in reducing primary accident costs.

(b) Specific or Collective Deterrence

In its purest form,

"specific deterrence suggests that all decisions as to accident costs should be made collectively through the political process. All the benefits and all the costs, including accident costs, of every activity, would be evaluated together and a collective decision would be made regarding how much of each activity should be allowed, and the way in which each should be performed".  

It is the situation of the state imposing collective decisions which in some instances, may prohibit certain activities (e.g. murder) and in other situations, limit the manner in which an activity may be performed (e.g. driving an automobile). Calabresi labels the above situations as "prohibition" and "restriction" respectively. Another scheme of specific deterrence is the limitation of an activity. "A simple limitation implies a decision that we want no more than a given amount of an activity but that collectively we are indifferent as to who engages in it or how it is performed". Calabresi suggests that the determination of who will participate in the restricted activity may be made by lot or according to a willingness to bear monetary or non monetary burdens imposed on the activity.
(c) Mixed Systems

In most instances, primary accident cost reduction will incorporate both the specific and the general deterrence approaches. For example, driving an automobile is limited to individuals over the age of 16 and is restricted according to a set of regulations known as the Traffic Code. In turn, motorists are expected to provide insurance to cover the cost of accidents. Presumably, the cost of insurance or the accident cost of driving is one of the costs considered by the motorist in his decision to engage in this activity.

Tort law is also a mixed system of accident deterrence. The decision of the court to impose liability on certain activities is essentially a collective decision and therefore, specific deterrence. The manner in which the deterrent is administered, however, is through the market mechanism of general deterrence. For the individual or enterprise directly involved in the judgement, the deterrent against continuing the behaviour is the "out of pocket" expense of the judgement. Conceivably, other individuals and enterprises which are also involved in the same area of activity as the defendant, will take into account the actual and potential costs of the new liability and decide, given the costs, whether the activity should be continued, altered or ceased. The difficulty with tort law as a deterrent, is that the deterrent is administered only after an accident has occurred and that other individuals and enterprises facing the new liability may not be aware of their new liability or may not internalize the fact that this new liability presents them with increased costs.

(2) Reducing Secondary Accident Costs

Secondary accident costs are those costs which result from an accident (e.g. health care cost, rehabilitation costs, loss of income, etc.). In
this situation, the accident has occurred and the aim is to find the
mechanism which minimizes both the costs and the impact of the costs.

It has been suggested that the overall impact of accident costs
would be less burdensome if:

(a) they are spread broadly amongst a large
group of people (i.e. the burden is less
if a $1,000 loss is spread equally amongst
1,000 people than if the full amount is
carried by one person) or

(b) they are placed on that category of people
least likely to suffer social or economic
dislocations as a result of the cost.

Although economists may argue over the validity of the above propositions
in specific cases, they appear to be reasonable in the general situation.
They both incorporate the spreading of costs although in the latter case,
the cost spreading is partial and selective. As a result, it is known
as the "deep pocket" approach.

If the avoidance of secondary accident costs were the only goal,
then the total spreading of all accident costs would be ideal. In other
words, all individuals would be expected to contribute to a pool from
which reimbursements for all accident costs would be allocated. The
contributions to the pool could follow a mechanism of progressive taxation
or even a deep pocket approach where the wealthy would be forced to
contribute a greater portion of their income than the poor. It is ap­
parent, however, that such a scheme would do nothing to promote the goal
of primary accident cost reduction since no financial penalty is directly
felt as a result of the accident.

In another scheme, individuals could be divided into risk categories
and each risk category would be expected to cover accident costs of the
individuals in that category. Such a scheme would provide some incentive
for primary cost reduction but would reduce the degree of cost spreading. It is therefore apparent that the goal of secondary cost reduction through cost spreading and that of primary cost reduction through general deterrence, are in opposition. Consequently, there is a trade-off between the degree of cost spreading of secondary accident costs and the degree of general deterrence of primary accident costs.

Calabresi notes that intertemporal spreading (i.e. the spreading of costs over time) may be as important as interpersonal spreading. Situations may exist where the individual sustaining the loss would be able to handle it if the losses occurred over a protracted period of time rather than at one point in time. The consumer of insurance often views the purchase of insurance in this way and such a situation may be closely reached in areas where the pooling of risk and consequently, the spreading of cost is very narrow (over a small group of individuals).

Finally, it should be noted that the process by which the compensation scheme may be administered may lead to increasing secondary costs. As Calabresi notes:

"One of the major charges being levelled against the fault system today is that it combines delay with uncertainty of compensation....This hampers rehabilitation and increases secondary losses substantially".

(3) Reducing Tertiary Accident Costs

Any system attempting to minimize primary and secondary accident costs must incur tertiary or administrative costs. Under certain schemes, the savings to be made in primary and secondary costs will be outweighed by the increase in tertiary costs. If the aim is to reduce total accident costs, such schemes should be rejected.
Medical Accident Cost Reduction

Before developing alternatives to medical malpractice litigation, it will be useful to examine with reference to Calabresi's scheme, the current mechanism of handling the costs of medical accidents in Canada.

1. Medical Malpractice Litigation as a Mechanism of Accident Cost Reduction

With respect to primary cost reduction, medical malpractice litigation may be seen as relatively ineffective. The system requires that doctors translate the outcome of litigation against their peers, into specific changes in their practice.

Although notable changes in judgement are well communicated in the professional literature and advice on medical jurisprudence is readily available, most doctors are not aware of this liability. A second problem lies with the limited scope of the court's judgement of liability. Many medical accidents occur which would not be classified as due to negligence and trespass. Consequently, no deterrent exists for the behaviour causing these accidents.

For those limited situations which are eligible, medical malpractice litigation provides a system for covering secondary costs. It should be noted, however, that medical malpractice litigation "combines delay with uncertainty of compensation" and consequently, increases secondary costs due to delays in rehabilitation.

In the case of medical malpractice litigation in Canada, the costs are spread equally among all doctors. This narrow pooling of risk aids in primary cost reduction although further pooling by specialty might be more effective in achieving this aim.

The costs of those accidents which are ineligible for compensation
through medical malpractice litigation must be borne by the individual affected. In most instances, his actions will have little impact in preventing future accidents of a similar nature and consequently, no incentive for primary cost reduction occurs. Individuals may be covered by disability insurance at their place of work in which case the accident cost would be spread among all employees insured. Additionally, the Federal Government, through its social insurance and unemployment insurance schemes, provides a limited amount of compensation. The cost in this case is spread among all taxpayers.

In all the above three situations there is no incentive for primary cost reduction, although they do assist in covering secondary costs.

The tertiary costs of litigation are considerable. Each case is treated individually, and the adversary process necessitates the hiring of lawyers and expert witness' as well as using the expensive machinery of the courts. The tertiary costs of disability insurance and government financed social insurance schemes are difficult to determine. Their costs per case, however, would be considerably less than litigation.

Overall, the above analysis suggests that medical malpractice litigation provides limited primary cost deterrence at a high tertiary cost. The costs of many accidents, however, are not eligible for compensation through litigation. Other compensation schemes provide some reduction in secondary costs, however, with no incentive for primary cost reduction.

2. Alternative Schemes of Medical Accident Cost Reduction - General Consideration

Calabresi's concept of accident cost reduction provides a useful scheme for developing and evaluating alternative systems of compensation for medical accidents.
Minimizing Primary Medical Accident Costs

As was discussed in Chapter III, due to his inability to determine his health requirements, the consumer of medical services allocates this responsibility to the provider (usually the doctor). Most decisions concerning health service utilization, and consequently, most decisions leading to medical accidents are made by the provider. It is the provider who consequently has the greatest opportunity to reduce the amount and severity of medical accidents.

(i) Specific or Collective Deterrence

In situations of relatively static technology, collectively determined rules provide a suitable means of deterring primary accident costs. For example, municipal building codes prescribe the acceptable format of plumbing, wiring and other aspects of house design, thereby preventing future accidents due to faulty design. The system of collective decision-making required to develop and amend such a code is relatively cumbersome and slow. Building technology, however, is relatively static and the losses due to the delay required to approve new technologies are outweighed by the ongoing benefit of accident deterrence. Medical technology, in contrast, is a rapidly changing technology which would not easily conform to a comprehensive code of rules or guidelines. In order to be effective, such a code would be in a constant state of revision and would Consequently present great difficulties administering. In addition, many of the rules would be of questionable validity due to the frequent difficulty in establishing definitive cause-effect relationships in medical treatment.

Tort law, in effect, currently provides a code by which physicians' actions should be governed (see Chapter IV). The code is voluntary and
not enforced by civil authorities. In turn, licensing bodies also provide a code governing both the ethical and clinical practice of the doctor (see Chapter II). It is notable that in both these cases, the "codes" tend to speak in generalities concerning acceptable and unacceptable patterns of clinical practice. Tort law speaks of "the reasonable doctor of ordinary prudence" and the professional code speaks of "failure to maintain the standards of practice of the profession". Both have proven difficult to apply in specific areas which no doubt reflects the great difficulty in legislating medical care.

In general, it may be said that specific deterrence provides an inappropriate vehicle for reducing the primary costs of medical accidents.

(ii) General or Market Deterrence

Since the potential to reduce the number and severity of accidents lies with the provider of medical services (the doctor), any mechanism of market deterrence should be administered on the provider. Towards this end, the cost of medical accidents could be directly levied on the physician providing the service. Conceivably, physicians would then avoid high risk procedures. The side effects, however, could be drastic. It would be expected that there would be a movement of physicians out of high risk specialities. This loss of expertise would not only result in a decrease in the number of high risk procedures performed but may also reduce the availability of potentially beneficial procedures normally performed by these specialists. A second effect would be the disincentive for clinical medical research. Although clinical research is often very risky, its long term effect may be the development of low risk procedures. The long term aim of developing low risk procedures would therefore be jeopardized by the short term aim of reducing accident costs. A final criticism is
LEAF 99 OMITTED IN PAGE NUMBERING.
that high risk procedures would probably be avoided to the extent that they would not be performed even when the potential costs of non treatment were higher than the potential accident costs of performing the procedure. In order to force the doctor to balance the costs of non treatment against accident costs, the costs of non treatment could also be levied against the doctor. Thus, a plan developed by Calabresi suggests that the patient's costs of loss of employment due to sickness as well as the costs of the patient's death, should also be levied against the doctor. This would conceivably provide the doctor with a financial incentive to provide the most appropriate treatment through the minimization of costs of sickness and costs of death.

(b) Minimizing Secondary Medical Accident Costs

As was indicated earlier in this chapter, complete cost spreading provides the ultimate means of reducing secondary medical accident costs. Such cost spreading could be provided through social insurance or "no fault" insurance schemes. Under such schemes, each participant in the medical care process would contribute to a central pool from which compensation for medically caused injuries or losses would be paid. The amount of contribution could be fixed or progressively based on the individual's ability to pay. The advantage of such a system is that compensation is guaranteed (i.e. secondary costs reduced) and that administrative or tertiary costs would be comparatively low.

It is obvious, however, that such a scheme would provide no incentive for primary cost reduction. If the degree of cost spreading is reduced by assigning the burden of covering the cost of medical accidents to the providers rather than the recipients of medical care, then some incentive for primary cost reduction would occur. Such a "deep pocket" scheme
would probably be socially acceptable since the medical profession is one of the most highly paid sectors of society. Moreover, such spreading would protect the individual doctor from extreme fluctuation in income incurred by directly covering medical accident costs.

The above system could be even more specific as a deterrent to medical accidents by pooling physicians according to their specialties. High risk specialties would therefore be subject to greater costs and a stronger deterrent than low risk specialties. Perhaps the most specific system of deterrence would be to rank procedures according to their risk and charge physicians a premium for each procedure performed based on this risk. It should be noted, that as the assignment of risk becomes more specific, the tertiary or administrative costs increase.

(c) Minimizing Tertiary Medical Accident Costs

In the sections above, the impact of various schemes on tertiary costs has been discussed. It is apparent that tertiary costs increase with the complexity of the system. Simplicity is the answer to minimizing tertiary accident costs.

3. Evaluating Alternative Schemes of Medical Accident Cost Reduction

Table XI presents an outline of the various goals or desired attributes of a system to replace medical malpractice litigation.

Table XI - Goals or Attributes of a System of Medical Accident Compensation

1. Total Cost Minimization
   (a) Primary Cost Minimization
   (b) Secondary Cost Minimization
   (c) Tertiary Cost Minimization

2. Practitioner Accountability

3. Accountability of the Profession
Total cost minimization, as divided by Calabresi into three sub goals of primary, secondary and tertiary cost minimization, is the first goal. The second and third goals of practitioner accountability and accountability of the profession are beneficial roles currently served by medical malpractice litigation (see Chapter II). Any alternative to litigation should therefore attempt to incorporate the achievement of these goals within its structure.

Several possible alternatives to medical malpractice litigation have been alluded to in the foregoing section of this chapter. These include social insurance schemes, no fault insurance schemes and Calabresi's scheme. In addition, it will be useful to examine "voluntary arbitration" since this promises to be the only successful alternative to litigation recently introduced in the United States.

(a) Medical Malpractice Litigation

In order to provide a benchmark for examining alternate schemes, the achievement of the goals by medical malpractice litigation should be reviewed.

Medical malpractice litigation provides a limited incentive for primary and secondary cost reduction since it applies only to those cases where negligence or trespass to the person can be shown. Unsuccessful and ineligible claims are not covered. In addition, medical malpractice litigation has extremely high tertiary or administrative costs. Although litigation promotes the goals of practitioner accountability and accountability of the profession, it is clearly ineffective in promoting medical accident cost reduction.

(b) Voluntary Arbitration

Ladimer and Solomon define arbitration as "a process, subject to law,
whereby parties may submit specified present or future controversies to a neutral party for final determination". The two parties jointly select an arbitrator (usually a lawyer) who will settle the dispute according to the current precepts of the law. The decision of the arbitrator is open to appeal, however, the appeal may be launched only on a point of law.

The advantages of voluntary arbitration over litigation are several. In the first place, the arbitrator is not tied to the procedural limitations of the court in hearing evidence and consequently, has greater flexibility in obtaining information pertaining to the case. Secondly, arbitration may tone down the adversary nature of the hearings. Thirdly, arbitration has potentially lower administrative costs, particularly since the findings of the arbitrator are binding and do not allow for appeals except on a point of law. Finally, arbitration has the potential to be less time consuming and less open to delay than litigation.

With the current tendency of the courts in Canada to favour the doctor, it is unlikely that voluntary arbitration would be accepted by the Canadian Medical Protective Association. This aside, voluntary arbitration has few advantages over litigation when it comes to accident cost minimization. Since decisions would be based on the accepted precepts of the law, success in arbitration would be limited only to those cases where negligence or trespass to the person may be shown. As a consequence, the deterrent value of arbitration would be limited. In addition, this would limit the situations in which secondary accident costs would be covered. As was mentioned earlier, however, arbitration could potentially reduce tertiary or administrative costs.

Arbitration would provide some practitioner accountability. Account-
ability of the profession, however, would be limited by the adherence of
the arbitrator to the accepted precepts of the law. This, in turn, would
reduce the already small volume of litigation, thereby reducing the op­
portunity for testing established precedents and developing new precedents.
(c) A Social Insurance Scheme

Under a social insurance scheme, all citizens would contribute to
a central, government administered pool which would be used to cover the
costs of losses due to medical accidents. In return for guaranteed com­
ensation, litigation would be disallowed.

Although social insurance would spread secondary costs over a large
population and thereby minimize these costs, it would fail to provide
any incentive for primary cost reduction. Tertiary or administrative
costs should be relatively low although difficulties in determining
whether losses resulted from medically caused injuries might raise these
costs.

A social insurance scheme could indirectly result in greater
practitioner accountability. The government would be able to monitor
the extent and nature of medical accidents and take action against
doctors found to be accident prone. Accountability of the profession
of medicine, however, would not be achieved.

Overall, a social insurance scheme provides coverage of secondary
costs at a medium tertiary cost. The scheme could potentially promote
practitioner accountability. The goals of primary cost minimization and
accountability of the profession would not be achieved.
(d) A No Fault Insurance Scheme

A "no fault" insurance scheme would see physicians provide insurance
to cover patients' losses due to medical accidents. Such coverage would be guaranteed, thereby doing away with the need to prove "fault" in the determination of who covers the cost of losses. In order to provide some specificity in deterrence, the pooling of risk in the above scheme would be according to specialty.

The pooling of risks and consequently costs, according to specialty would provide an incentive for primary cost reduction. Secondary costs would be covered by spreading the costs over a small group. Nevertheless, such narrow cost spreading would probably be acceptable, due to the generally high incomes of physicians. Compared to litigation tertiary or administrative costs would be relatively low. Neither practitioner accountability nor accountability of the profession would be maintained in a no fault system.

Although this scheme promises to produce low accident costs, it has one major disability, it would promote non treatment of the patient in situations where the costs of non treatment are greater than the potential accident costs of treating the patient.

(e) Calabresi's Scheme

Calabresi visualizes his scheme as occurring within the framework of a Health Maintenance Organization (H.M.O.). The H.M.O. would not only contract with the patient to provide all medical services, but also contract to provide unemployment insurance and life insurance. Calabresi visualizes the doctor as being a salaried employee of the H.M.O. However, it would probably be necessary to tie the doctor's remuneration more closely into the financial performance of the H.M.O. if any influence is to be exerted over his clinical behaviour. It will be assumed that such
a system has been instituted.

The incentive in Calabresi's scheme is not only to keep the patient alive but also to keep him productive. Theoretically, the doctor would consider, in terms of his economic loss, the risks of death or disability of treating the patient according to different modes of treatment. He would then choose that treatment with the lowest risk and thereby minimize his losses. This theory may be questioned on three points. In the first place, it is questionable whether the economic incentives proposed are sufficiently strong to intrude significantly into medical decision making. Secondly, it is doubtful whether doctors would be able to determine the true risks of treatment. Finally, the degree of influence of the doctor's actions over the occurrence of death or disability may be exceedingly limited. Nevertheless, Calabresi's scheme presents a novel proposal to focus the physician's attention not only on the medical outcome of the treatment but also on the implications to the patient of that outcome.

In Calabresi's scheme, the major secondary costs of medical accidents, death and unemployment, would be covered. To obtain compensation for other losses or costs would require the patient, or his family, to undertake litigation proceedings. Finally the administrative costs of Calabresi's scheme would be comparatively low when compared to litigation.

Although the scheme provides virtually no direct opportunity for practitioner accountability, its economic incentives could, in effect, achieve that goal. Physicians with poor judgement records could find themselves priced out of practice as a result of high insurance premiums. With respect to accountability of the profession, the scheme would be relatively ineffective.

Overall, Calabresi's scheme promises to provide relatively low ac-
cident costs with a limited degree of practitioner accountability.

Conclusions

If, as Calabresi contends, the real goal of accident law is the minimization of accident costs, then medical malpractice litigation is relatively ineffective. It provides limited minimization of primary and secondary costs at a high tertiary or administrative cost. Voluntary arbitration is similarly inclined, although under arbitration there is a potential for reducing administrative costs. Arbitration, however, would reduce the opportunity for the development of new precedents, and consequently, accountability of the profession would be restrained. A social insurance scheme would effectively cover and thereby minimize secondary costs at a low tertiary cost. It would, however, provide no incentive for primary cost minimization. No fault insurance would potentially produce low accident costs. It would, however, fail to account for situations in which the costs of non treatment are greater than the potential accident costs of treatment. Finally, Calabresi's scheme promises to produce relatively low accident costs. It is, however, based on a number of questionable premises.

In the final analysis, there is no perfect scheme for accident cost minimization. In theory, Calabresi's scheme would be most effective in achieving this goal. It presents a novel approach in providing an incentive to produce the optimum result of the doctor-patient encounter. Its shaky theoretical foundation, however, leads to the suggestion that it should be studied and tested in a pilot project before being attempted on a wider scale.

2. IBID, p. 27.


7. Disability Insurance provides income protection for those fortunate enough to be covered by their employer.


11. IBID, p. 68.

12. IBID, p. 95.

13. IBID.

14. IBID, p. 113.

15. IBID, p. 115.

16. Such a scheme is often found in the provision of insurance through private companies.


18. IBID, p. 278.


22. Haines argues that the adversary system is an unsatisfactory way of settling a medical malpractice dispute. He suggests that the adoption of an "Inquisitorial" system of justice, as found in Germany, would be more appropriate. E.L. Haines, "The Medical Profession and the Adversary Process," Osgoode Hall Law Journal 11 (January, 1973):41-53.

24. Calabresi, "Medical Malpractice".
CHAPTER VII

CONCLUSIONS

In addition to the general conclusions of the study, it is only fitting (since this thesis is a requirement for a degree in health services planning), that an examination be made of the implications of medical malpractice litigation on planning in the health care sector.

Implications of Medical Malpractice Litigation on Planning

In Chapter VI, it was noted that judgements of litigation in effect provide an informal "code of behaviour". It is informal in that it is not codified or formally enforced except through the process of litigation. Compliance with the code is not mandatory, however, certain liabilities are accepted if the code is not followed.

With respect to medical malpractice litigation, the code provides guidelines for the performance of activities, not only by physicians, but by all sectors of the health care system. For example, the court has ruled that surgeons are expected to ensure that instrument and swab counts are correctly performed before and after all operations. In turn, hospitals are expected to provide the necessary resources to enable these counts to be adequately performed.

If the rulings of the court influence the way activities in the health care system are performed, then planners must also take them into account when developing new or alternate modes of delivering health
services. The rulings of the court, along with the numerous statutes related to health and the provision of health services, consequently provide a basic set of planning constraints.

The impact of court rulings on the planning process in Canada is relatively minor. This is to be expected, since in Canada the courts are not viewed, nor have they accepted, a legislative role. The impact of legislation, however, is considerable.¹

The placing of health under the jurisdiction of the provinces in the British North America Act has led to provincial control over the planning and the provision of services. This has placed a considerable constraint on the Federal Government in its efforts in the health planning field. For example, in order to achieve its aim of ensuring the provision of medical services for all citizens through a government financed health insurance scheme, the Federal Government was forced to resort to bribery in the form of a 50:50 cost sharing scheme. In return for covering 50% of the costs of the plan, the Federal Government specified certain conditions to which the provincial plans would have to conform (e.g. universal coverage, portability etc.).² Having achieved their purpose of the implementation of a relatively standard and comprehensive form of government financed medical care insurance, the Federal Government has recently negotiated its way out of the cost sharing agreement.

The above example presents the situation where legislation affects the implementation process. In turn, legislation can also affect the planning process. For example, the Federal Government has been attempting to develop a sophisticated data file on Canadian physicians for the purpose of manpower planning. In view of the considerable initiative taken
by the Federal Government in an area of provincial jurisdiction, the provinces have demanded greater consultation in this matter. The overall effect has been that the Federal initiative has been stiffled, while the Federal Government seeks the co-operation of each of the provinces. 3

Similar administrative constraints not only face planners at the Federal level but also at other levels of the health care system. A good example is the transfer of procedures traditionally performed by physicians to other health workers. Proposals for such transfers are usually based on the proposition that the other category of health workers can perform the procedure as competently or better than doctors and at a lower cost. For example, in the neonatal intensive care unit at The Hospital for Sick Children in Toronto, it was proposed that special procedure nurses be authorized to perform "heelstick punctures" to obtain blood for biochemistry tests. 4 The motivation for the proposal was that the area was understaffed with physicians and that this procedure could best be performed by the special procedure nurses. Since "heelstick" punctures lie within the domain of the practice of medicine, permission was sought from the College of Physicians and Surgeons of Ontario to allow nurses to perform this procedure. The College stipulated that only nurses who had undertaken an approved special course could be authorized to perform the procedure.

There is a limited danger in the above system in that it is possible that the courts could over-rule the decision of the College or licensing body authorizing the transfer of responsibility. Such a decision could conceivably place the licensing body in a position of liability with respect to a malpractice claim. The transfer of responsibilities from physicians to other less qualified and less expensive practitioners,
therefore, presents a particular problem to the health planner in that it may only be achieved with great difficulty.

In conclusion, the impact of medical malpractice litigation on health care planning in Canada is minimal. Of far more significance is legislation. This provides considerable constraints to the planner in developing and particularly implementing his plans. In the United States where the judiciary plays a legislative role, the impact of litigation on health care planning is probably greater.

Conclusions of the Study

Overall, the study suggests that medical malpractice litigation provides an inadequate scheme for compensating patients for losses due to medically caused injuries. Not only is it applicable to a limited number of medical accidents (i.e. those caused by negligence or trespass to the person), but it also presents barriers to eligible claims. Finally, it provides little or no incentive for accident costs minimization.

After examining a number of alternatives to litigation, the study suggests that there is no ideal scheme for compensating patients for losses resulting from medical accidents. A scheme developed by Calabresi shows some promise. This scheme involves doctors providing their patients with unemployment insurance and life insurance coverage. Presumably, the economic incentive under such a scheme would be to keep patients alive and productive.

The scheme would face a variety of problems in implementation, the most notable being physician resistance. The medical profession would argue, with some justification, that they would be liable for costs which are often beyond their control (i.e. due to personal habits or environ-
mental factors). Nevertheless, the proposal deserves to be tested. In particular, certain of the assumptions of the scheme (e.g. that doctors' clinical behaviour may be altered through economic sanctions) needs testing, and this could best be achieved through a pilot project.

In the meantime, there is a need to revise the current scheme of compensation through tort law. Special statutes of limitation not only for physicians, but also for hospitals, deserve to be abolished. "Costs of court" should only be assigned against the plaintiff in situations where the plaintiff's claim is clearly of questionable merit. Other possible areas of reform which require more study and consideration include the allowance and expansion of contingency fees and the allowance of the doctrine of "res ipsa loquitur" in medical malpractice cases.

The study has also suggested other areas that may require reform. With respect to mechanisms of accountability, it is suggested that hospitals should increase the scope of accountability they require of physicians. This is slowly being forced on the hospitals by the Canadian Council of Hospital Accreditation. Provincial licensing agencies need to be more visible. Their complaint and disciplinary responsibilities should be advertised on a continuing basis to ensure that the population is aware of their existence. In addition, lay representation should be on all complaint and disciplinary committees, and the decision of these committees should be subject to appeal to an impartial authority. Finally, licensing agencies should monitor all malpractice suits within their jurisdiction and take disciplinary action when it is warranted.

A final area that requires reform is the Canadian Medical Protective Association. Due to its overwhelming emphasis on protecting its members, the C.M.P.A. has developed a reputation of being uncompromising and
unsympathetic. These criticisms aside, the C.M.P.A. has failed to grasp an additional role of attempting to prevent the actual occurrence of medical malpractice. The C.M.P.A. needs to change its emphasis from one of protection to one of prevention. It is in an ideal position to accept such a role since it not only has high legitimacy in the eyes of the medical profession, but also is aware of the many reasons behind successful and unsuccessful malpractice claims. Towards this end, the C.M.P.A. should collect meaningful statistics not only of the volume and cost of litigation, but also of the causes of litigation. In addition, it should attempt to inform and educate its members in matters of medical jurisprudence.
FOOTNOTES - CHAPTER VII

1. It is a paradox that legislation often provides the vehicle for the implementation of plans. Once implemented, however, that legislation provides a constraint for the development of future plans.


3. The author is currently employed in the Ontario Physician Manpower Data Centre and has consequently been able to directly observe the manoeuvring of the various parties involved in physician manpower planning in Canada.

4. The author was previously employed by The Hospital for Sick Children, Toronto, and was consequently able to observe the process of this transfer of function from physicians to nurses.

5. Krever provides a thorough discussion of the conditions under which res ipsea loquitur should be allowed in medical malpractice claims in Hobson v. Munkley (1977), 14 O.R. (2d) 575
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BOOKS


ARTICLES


ARTICLES


ARTICLES


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STATUTES


GOVERNMENT REPORTS


MISCELLANEOUS


Dear

As a requirement for a Master's degree in Health Services Planning, I am writing a thesis on medical malpractice litigation. Litigation provides one mechanism by which the consumer of health services can censor the provider. Conceivably, another mechanism is to withhold payment of the fee to the provider. Since in Canada, fee payments to doctors are now controlled by a third party (provincial governments), I am interested in determining how this third party would respond to the consumer's request to withhold payment. Since, in your province, your organization is responsible for the payment of medical fees, I would greatly appreciate an indication of how you would respond to a request from a consumer of medical services to withhold payment of fees to a doctor. I would also be interested in knowing whether you receive such requests.

Thanking you in advance for your assistance.

Sincerely,

Alastair Macdonald,  
Administrative Assistant  
Department of Paediatrics
QUESTIONNAIRE

Province ________________________________

Name of Licensing Body ________________________________

Name of Individual Completing the Questionnaire ________________________________

Position of Individual Completing the Questionnaire ________________________________

Telephone Number ________________________________

1. Describe briefly how your organization handles verbal (e.g. telephone) complaints concerning a licensed doctor.

2. Describe briefly how your organization handles written complaints concerning a licensed doctor.
3. What is the composition of your disciplinary committee (e.g. 3 doctors, 1 lay member)?

4. How and by whom is the disciplinary committee appointed?

5. Is your organization involved in the negotiation of fee schedules with the provincial government?
   - Yes
   - No

6. Do you automatically review all confirmed cases of medical malpractice to determine whether disciplinary action should be taken?
   - Yes
   - No

If yes, how do you monitor both "out of court settlements" and "in court judgements"?
7. If the following data is available, please complete the following table.

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8. Do you have someone available during regular office hours (9:00 a.m. to 5:00 p.m.) to handle complaints?

Yes

No

If yes, who? (title) ________________________

9. Do you anticipate making any notable changes in the system of handling complaints and disciplinary proceedings in the near future? Please specify.
Appendix C.

the list of certificants or Fellows of that College shall not use a specialty qualification in any branch of medicine. O. Reg. 577/75, s. 22.

23.—(1) The Council shall determine the information required for the compilation of statistics with respect to the supply, distribution, qualifications and professional activities of members and may direct the Registrar to obtain the required information.

(2) Upon the written request of the Registrar, members shall provide to the Registrar the information requested for the compilation of statistics. O. Reg. 577/75, s. 23.

24. The Registrar is the chief administrative officer of the College and is subject to the direction of the Council. O. Reg. 577/75, s. 24.

25. The decisions of the Discipline Committee shall be published by the College in its annual report and may be published by the College in any other publication of the College, and where a member has been found guilty of professional misconduct or incompetence, the full name and address of the member may be stated and a summary of the charge, the decision and the penalty imposed may be stated and the text or substance of any restriction on the licence of the member or of any reprimand may be added, but where a member has been found not guilty of professional misconduct or incompetence, the identity of the member shall not be published but the substance of the proceedings may be published without identification of the parties for the purpose of publishing advice to the member or to the profession. O. Reg. 577/75, s. 25.

*** 26. For the purpose of Part III of the Act, "professional misconduct" means,

1. failure by a member to abide by the terms, conditions or limitations of his licence;
2. contravention of any provision of Part III of the Act, The Health Insurance Act, 1972 or the regulations;
3. failure to maintain the records that are required to be kept respecting a member's patients;
4. having a conflict of interest;
5. using a term, title or designation other than one authorized or using a term, title or designation that is prohibited by this Regulation;
6. permitting, counselling or assisting any person who is not licensed under Part III of the Act to engage in the practice of medicine except as provided for in the Act or this Regulation;
7. charging a fee that is in excess of the fee in the schedule of fees of the Ontario Medical Association without prior notification to the patient as to the excess amount of the fee;
8. charging a fee that is excessive in relation to the services performed;
9. failure to carry out the terms of an agreement with a patient;
10. selling a professional account to a third party;
11. refusing to render a medically necessary service unless payment of the whole or part of the fee is received in advance of the service being rendered;
12. requiring payment for a service that is insured under The Health Insurance Act, 1972 as a condition to be met before completing a claim card for submission under that Act or, before providing an itemized account of the services where a request is made for an itemized account by the patient or a representative of the patient;
13. offering a reduction for prompt payment of an account or charging interest except where interest has been granted in a judgment of a court;
14. charging a fee for services not performed;
15. falsifying a record in respect of the examination or treatment of a patient;
16. knowingly submitting a false or misleading account or false or misleading charges for services rendered to a patient;
17. announcing or holding out to the public that the member is a specialist or is specially qualified in a branch of medicine where the member is not qualified as a specialist;
18. engaging in the practice of medicine while the ability to perform any professional service is impaired by alcohol or a drug;
19. contravening while engaged in the practice of medicine any federal, provincial or municipal law, regulation or rule or a by-law of a hospital designed to protect the public health;
20. failure to maintain the standard of practice of the profession;
21. giving information concerning a patient's condition or any professional services per-
formed for a patient to any person other than the patient without the consent of the patient unless required to do so by law;

22. failing to continue to provide professional services to a patient until the services are no longer required or until the patient has had a reasonable opportunity to arrange for the services of another member;

23. making a misrepresentation respecting a remedy, treatment or device;

24. failing to reveal the exact nature of a secret remedy following a proper request for such information;

25. improper use of the authority to prescribe, sell or dispense a drug, including falsifying a record in respect of a prescription or the sale of a drug;

26. failing to provide within a reasonable time and without cause any report or certificate requested by a patient or his authorized agent in respect of an examination or treatment performed by the member;

27. failing to carry out the terms of an agreement or contract with a hospital;

28. sexual impropriety with a patient;

29. sharing fees with any person who has referred a patient or receiving fees from any person to whom a member has referred a patient or requesting or accepting a rebate or commission for the referral of a patient;

30. publishing, displaying, distributing or using or permitting, directly or indirectly, the publishing, display, distribution or use of any advertisement related to the practice of medicine by a member other than,

(i) professional cards that contain only the name of the member, a vocational designation, academic degrees, the member's address and telephone number,

(ii) an announcement upon commencing practice or changing the location of a member's practice that,

a. does not exceed two standard newspaper columns in width and ten centimeters in depth,

b. does not contain references to qualifications, procedures or equipment but may contain academic degrees, and

c. does not appear more than three times in a newspaper in respect of the commencement of the practice or of a change in the location of the practice,

(iii) appointment cards that do not contain more than the information contained in a professional card and the time and date of the appointment or appointments,

(iv) a telephone directory listing,

a. in the white pages that,

i. is of dark or light type,

ii. where a member is a certificated specialist, may indicate the specialty designation,

iii. where a member who is not a certificated specialist restricts his practice to one branch of medicine may insert after his name "Practice limited to............"

iv. does not list office hours, and

v. where the practice of medicine is carried on as a partnership, clinic, medical centre or other form of medical group lists the name of the partnership, clinic, medical centre or other form of medical group and the names of the members with their designations thereunder;

b. in the yellow pages that,

i. is listed only in the section "Physicians and Surgeons",

ii. is only of light type,

iii. where a member is a certificated specialist may indicate the specialty designation,

iv. where a member who is not a certificated specialist restricts his practice to a branch of
(3) It is a conflict of interest for a member where the member or a member of his family, 

(a) accepts rebates from a vendor of medical appliances, drugs, materials or equipment or from a person licensed or registered under any Act regulating a health discipline; 

(b) accepts credit from a vendor of medical appliances, materials, equipment or drugs, or from a person licensed or registered under any Act regulating a health discipline except where the terms of the credit provide a reasonable time of repayment, a reasonable rate of interest on the amount outstanding at any time during the period of credit, and the credit is not related to the referral of patients to the creditor; 

c) rents premises to a tenant who is a person licensed or registered under any Act regulating a health discipline except at a rent normal for the area in which the premises are located and the amount of the rent is not related to the volume of business carried out in the premises by the tenant; 

d) rents premises from a vendor of medical appliances, materials, equipment or drugs, or from a person licensed or registered under any Act regulating a health discipline except at a rent normal for the area in which the premises are located and the amount of the rent is not related to the referral of patients to the landlord. 

(4) The selling or supplying of a drug, medical appliance, medical product or biological preparation by a member to a patient at a profit is a conflict of interest, except where the drug is necessary, 

(a) for an immediate treatment of the patient; 

(b) in an emergency; or 

c) where the services of a pharmacist are not reasonably readily available. 

(5) Notwithstanding subsection 4, it is a conflict of interest for a member to sell an allergy preparation that he has prepared for his patient for a price that exceeds, 

(a) the true cost of production of the preparation; and 

(b) the fee for the professional component, for the member’s review of the case, prescription of the material and general supervision of the member’s laboratory in preparing the material. O. Reg. 577/75, s. 27.