MEDICAL MALPRACTICE: PATHOLOGY AND THERAPY

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1.- In most western countries, and more particularly in North America (1), there is a growing concern for the increasing amount of malpractice claims against physicians, medical staff and hospitals. A second concern appears to be the increase in the amount of damages awarded by the courts. These are perceived to be exorbitant and overly generous.

2.- Criticisms have been voiced by individual physicians, their representative associations, as well as by insurance companies. A number of insurance companies now refuse to cover certain medical risks altogether, or are demanding premiums that are sometimes two or three times the rates charged a few years ago.

3.- Lawyers, on the other hand, are often accused of taking advantage of the situation by capitalizing on the increased severity of the courts in the control of medical acts, and by artificially inflating the demands in damages, in the hope of getting increased and more substantial fees.

4.- Lawyers and physicians have joined forces in criticizing insurers and in accusing them of provoking an artificial panic situation in order to raise premiums and to increase their profit margins in an unconscionable way.

5.- This however is not a new development. This situation is somewhat paroxistic in the United States. The conflict between insurers, lawyers and professionals has existed in Canada for sometime. To a

certain extent, the present situation is similar to the sometimes acrimonious conflicts that opposed these groups a few years ago. For instance, when the no-fault automobile compensation scheme was set up in Quebec (2).

6.- The question today is whether or not the present state of the law on professional liability in health care cases is contrary to good medical care?

7.- The issue is indeed a complex one that would require extensive sociological and scientific studies to determine whether on not physicians are aware of the present state of the law, and whether or not this knowledge has a significant impact on their practice (3). In attempting to provide at least a general answer, I have organized my remarks on two different levels. The first is a critical examination of the present law; the second is an attempt to identify potential reforms. This, hopefully will allow us on the one hand to pinpoint the defects of the present system and to isolate those rules that may have a negative impact on medical practice, and, on the other hand, to discuss more accurately reforms that could be in the interest of both law and medicine.

I - MALPRACTICE: THE PATHOLOGY

8.- The present legal system is attacked on two fronts. The first is a qualitative one: it is argued that the increased severity of the courts is the result of a change in attitude toward health professionals who are found to be negligent more easily now than a few years

ago. The second is a quantitative one: whereas, it is argued, damages awards before 1978 were reasonable, they are so high now that they have become unbearable for the system as a whole.

A. THE INCREASE IN MEDICAL MALPRACTICE

9.- In recent years, there is little doubt that malpractice cases against physicians and hospitals have increased significantly (4). This observation however must be put back into context. Firstly, a number of statistics and observations are drawn from U.S. sources, and made indiscriminatly applicable to Canada. This contributes to the fostering of a certain degree of medical paranoia that is simply not consistent with the reality. The American picture, especially as reported by newspapers and magazines, bears no ressemblance with the Canadian situation. One cannot simply draw the conclusion that because the United States is undergoing a serious crisis in this respect, a comparable crisis exists or will soon exist in Canada. Secondly, it would be wrong to make the law solely responsible for this change in attitudes. A certain number of other social and cultural factors must be taken into account.

10.- The first one is the appearance of what one may call "professional services consumerism". By the late 1960's, consumer protection schemes began to appear in Canada. Various provincial laws have now recognized this movement. Consumerism is a vocal movement and the general attitude that it reflects is encouraged by law: Should the product not be identical to its representation; should it not correspond closely to the

consumer's desire; should it become too quickly obsolete, the law will bring relief to the consumer, through a system of rules that are totally contrary to the traditional common or civil law traditions. The law is prejudiced in favour of the consumer. The general attitude of consumerism was first reserved to the consumption of goods. It then slowly extended to certain types of services (automobile repairs for instance) and then to the sector of professional services. Fifty years ago the Canadian patient (except in cases of gross negligence) hesitated to sue his or her doctor. This attitude is now a thing of the past. In the same way as a car buyer will not hesitate to seek redress from the vendor and the manufacturer, the modern patient, unsatisfied with medical services will not hesitate to take the physician to court. Restraint in medical malpractice is simply gone!

11.- This attitude has most certainly been fostered by the increased socialization of medicine in certain provinces like Quebec. The Canadian citizen, by his taxes, pays for what he now sees as a "public service". He feels he is always entitled to more and better services.

12.- A second factor is the drastic change that took place in the physician-patient relationship. For a number of years this relation was basically an authoritarian and unilateral one. The physician in fact often decided alone what was in the patient best interest, and on his own proceeded to take the appropriate measures. The consent of the patient, his involvement in therapeutic choices was minimal. This is no longer the case today, and the relationship is much more egalitarian. The patient

has a say in medical decisions which are becoming more and more the product of a bilateral and mutual process.

13.- This change has brought about a substantial increase both in the quantity and quality of the information that must be communicated to the patient, making it increasingly difficult for health professionals to hide certain mistakes or problems or to blame fatality for bad results. The physician is no longer seen as a sort of "Semi-God" or a "Miracle Worker" and has lost the artificial prestige attached to these images. He is now seen as an ordinary human being fully accountable for his mistakes.

14.- A third phenomenon is the shift from medicine as an art to medicine as a science, at least in the public perception. Modern scientific developments have greatly altered traditional medical practice. The modern physician, whether in specialized or general practice, no longer makes a diagnosis or undertakes treatment without submitting his patient to a series of scientific tests. Doctors no longer trust a diagnosis based solely on personal observation. In the mind of the public, science is largely thought to be infallible, making it more difficult to accept that physicians, helped as they are by scientific logistics, can still make mistakes at interpretating of tests and in administering treatment.

15.- Physicians are probably the involuntary victims of a somewhat unrealistic perception of reality. This perception however is very real. The public tends to consider medicine as an exact science with a high

degree of predictability and no longer as the practice of an art. The public is no longer conditioned to accept limits and failures.

16.- Many other psychological and sociological factors could be discussed here. It would, however take too long to examine them in details. Such an examination, moreover is not necessary to make the point that changes in the law are not the only reasons for malpractice claims increase. Yet a number of legal factors do have an interesting impact. I will briefly examine three specific ones: the rise of the judicial standard of negligence; the extension of causation and the increased importance of informed consent.

1) THE RISE OF THE JUDICIAL STANDARD OF NEGLIGENCE

17.- There is no doubt that by and large, Canadian courts have changed the traditional standards of fault in civil law and negligence in common law. Courts have become more exacting for professionals and will find negligence more readily now for certain types of conducts that, 25 years ago, would have been found to measure up to required standards.

18.- There now is a "blurring" of the frontier between "fault" and "mistake" (5). In classical theory, medical negligence is a conduct that a normally prudent and diligent physician would not have had in circumstances similar to that of the case (6). Fault or negligence reflects a socially unacceptable professional behaviour. Traditionally, the general duty of the physicians is one of means, not of results. It follows that

the reasonable physician may sometimes make mistakes or errors of judgment which will not necessarily be actionable. The concept of "error of judgment" is well known to common law courts (7).

19.- Both in Quebec and in the common law provinces, a few years ago, courts did, perhaps instinctively, draw a distinction between negligence and a simple mistake. This separation is now blurred and often the simple mistake is taken to be a civil fault (8).

20.- Secondly, at an evidentiary level, there is a decrease in both the quality and quantity of evidence required from the plaintiff. This may be due in common law to an extension of the "res ipsa loquitur" rule (9) and in civil law, to a more liberal application of the rules concerning presumptions of facts (10). The "unexplained" medical accident, that should not have normally occurred, is no longer seen as a stroke of destiny. Increasingly, hospitals and physicians are required to provide a precise explanation of what happened. In the absence of a satisfactory answer, courts will more readily presume their liability.

2) THE EXTENSION OF CAUSATION

21.- Malpractice cases are often won or lost at the level of causation. Causation is an extremely complex philosophical and legal issue which cannot be examined in details here (11). A few general remarks however must be made.

22.- Firstly, there exists a tendency (which is not new by any means) for courts, faced with a situation consistent with intentional or gross negligence, to dispense with the examination of causality. The seriousness of the fault and the existence of a prejudice, are deemed enough to lead them to conclude to the existence of a causal connection.

23.- The second and third remarks concern more specifically the common law area. This is an area where substantial differences separate our two legal systems.

24.- In common law, the generally accepted test is that of the "condictio sine qua non" the "but for ..." test (12), even if more recently by reference to the informed consent doctrine, this approach appears to have been somewhat softened (13). Courts, therefore generally will ask themselves the following question: Had it not been for the conduct of the defendant, would the damage still have occurred?"

25.- In medical malpractice cases however the theory of "proximate cause", developed by case law as a buffer to a strict application of the condictio sine qua non, has had a significant impact. The physician will sometimes be held liable only for those damages that were reasonably foreseeable by a reasonable person in the same circumstances.

26.- In Quebec civil law, the situation is somewhat different. Quebec courts treat causation mainly as a question of facts. In general "adequate causation" is a generally adopted theory (14). Courts will try to isolate cause from circumstances, and exclude certain factors that

would qualify otherwise as conditions sine qua non. Moreover, Quebec courts in delictual liability will also refer sometimes to a test of reasonable foreseeability, which normally, under strict civil law rules should only be used in contractual matters (16). It can perhaps be argued (but not being a specialist of common law, I will present this remark as a simple hypothesis) that because of the greater flexibility of common law in this respect, the potential for retention of liability is also greater.

27.- Finally one can wonder whether the recent Kamloops Case (17) of the Supreme Court, which throws the net of causation very wide, will not have an impact on medical cases. This case, in all respect for the contrary view, should not, in my opinion, be made applicable to civil law.

3) THE INCREASED IMPORTANCE OF INFORMED CONSENT (18)

28.- Hopp v. Lepp (19) and Reibl v. Hughes (20), have significantly changed the common law rules on informed consent. In 1980, the Supreme Court literally abandonned the "professional disclosure test" for a wider "full disclosure standard". The physician must now describe to the patient all the risks that a reasonable patient under similar circumstances, would have wanted to be divulged.

29.- Here again civil and common law do part. Under civil law to be at fault, a physician must have failed to reveal to the patient what a

reasonable physician under the same circumstances would have revealed. One may think, at first glance, that the civil and the former common law rules are identical. This is not so however because even if the civilian test is centered on the physician and not on the patient, it does require taking into consideration all the circumstances of the case, and thus, amongst others, the individual characteristics of each patient (21).

30.- The new content of the duty to inform, as interpreted by case law, will no doubt have a determining impact on liability (22). The physician's duty has been considerably developed. The risks of mistakes, of lack of information, or of information effectively communicated but not understood by the patient, are now borne by the professional. It seems reasonable to predict that the influence of the new egalitarian approach to the physician-patient relationship and of American ideas will probably be felt also in Canada. The extension of the physician's duty to inform will also have as an important consequence that in practice a number of plaintiffs will more readily invoke wrongfull omission of information as a basis for their claim, rather than discharge the burden of proving negligence in diagnosis or treatment.

31.- In Quebec the enforcement of informed consent rules has raised some specific difficulties. A few isolated cases (23) have, unknowingly, changed the traditional approach, by holding, even where treatment has been successful and the physician has not committed any negligence in its administration, that the defendant can still be held liable for all the damages if he has failed to discharge the duty of informed consent. A finding of liability is, I believe consistent with the law,

since such failure is indeed a civil fault. However, the consequences that are then drawn from that finding, (that the physician is responsible for all the damages incurred) is, in my opinion debatable. Are really all the damages suffered by the plaintiff a necessary consequence of a failure to properly inform? Instead, should not the true measure of damages be that of a "loss of chance" (24)? If this was held to be the proper basis of evaluation, it is not all damages that would be open to compensation, but only the direct consequences of the deprivation of a choice? It seems to me that to hold the physician responsible for all the non-negligent consequences of a treatment that was well administered but not properly consented to is, in effect, transforming the duty to treat, when consent has not been informed, into an obligation of guarantee or result. This, in my opinion is subject to debate.

32.- In conclusion on this first point. I believe that there is truth in the proposition that case law has reinforced the traditional standards of negligence or fault vis-à-vis health professionals who can now expect a more vigorous scrutiny of their behaviour. It remains to be seen, however, if this should necessarily be interpreted as negative change in the law.

B. THE INFLATION OF DAMAGES AWARDS

33.- My comments on this subject will be very brief, for two reasons. Firstly, the problem, if there is a problem, is not specific to medical malpractice but affects tort law in general. Secondly, an

in-depth study of the question would indeed require a seminar in itself to measure the economic, sociological and legal impact of the Supreme Court trilogy of 1978 (25). This clearly would be outside the purview of this short presentation.

34.- It is a fact that the average award for damages claim has substantially increased since 1978. Several hundred thousands of dollars, or even millions, are now awarded by the courts. For physicians, this is by definition a negative change, for it means a substantial increase in insurance premiums and in some cases, the inability to obtain insurance coverage, and a sword of Damocles than can ruin the professional's career.

35.- Yet the courageous reform of 1978 was both necessary and desirable. Necessary, because prior to the Supreme Court trilogy, there was no rational and scientific method of damages evaluation. The judicial techniques were then lacking scientific basis. The "just and equitable indemnity", the "discount for contingencies of life", the lump "overall assessment technique" resulted in undercompensation for victims who had suffered significant damages. Unlike other groups (workers, automobile accident victims), these individuals were not even guaranteed a minimal indemnity under a no-fault scheme. They assumed both risks of losing the case and of not being adequately compensated. Fortunatly the Supreme Court did propose a rational and articulate system. It is of course possible to criticize certain rules or certain aspects of the Supreme Court trilogy (for instance the ceiling put on compensation of non-economic damages, or the adoption of the functional theory). Yet, in the absence

of direct legislative intervention, the Supreme Court handbook of assessment of damages constitutes a remarkable example of creative case law.

36.- It is not surprising, accustomed as we were, to minimal indemnities, seldom going over the one hundred thousand dollars mark that awards in the range of a million dollars scare a lot of people. May I suggest however that, instead of being scared, we should think about those victims who have been compensated prior to 1978 and who now have no money left.

37.- Once again I do not mean to say that the present system is the most appropriate one, and that it should be kept as is. Some reforms can be made. My contention is much more modest: Within the framework of the present system, the rules set out by the Supreme Court, now allow the courts to grant victims a just, reasonable and fair compensation for their losses.

II - MALPRACTICE: THE THERAPY

38.- The vast majority of Canadian lawyers do believe that the present system can be perfected and be made more equitable for all concerned.

39.- As for medicine two possibilities are open. The first is conventional therapy which consist, within the actual framework of tort law based on fault or negligence, to identify the main problems and to

reform the law. The second is innovative or shock treatment. It requires, as a certain number of countries have already done, to review the basic premises of the traditional tort system as a whole.

A. CONVENTIONAL THERAPY

40.- The present system could clearly benefit from some simple reforms. It is impossible at this particular moment to review all the possibilities. I will only attempt to deal briefly with those which appear to me the more fundamental reforms from a substantive law point of view, as well as from the point of view of procedure and evidence rules. Comparison with American law and experience is vital in order to gain a better understanding of what went wrong in a system that often exagerated certain defects.

1) SUBSTANTIVE RULES

41.- The development of the law of torts should be left mainly to the creative thinking of the courts. Courts should, within the general system of civil and common law, articulate the basic concepts of negligence and fault, as well as that of causation. One could perhaps wish however for a stricter definition and practical application of fault and negligence. The duties of the physician should not be widened to cover risks and thus gradually be transformed into an obligation of guarantee or even of result. Courts must sanction negligent medical conduct, for vic-

tims are entitled to being compensated. They perhaps should be stricter on the quality of evidence required to demonstrate fault or negligence, for physians and hospitals should not be made responsible for mere "therapeutic accidents".

42.- The present system of civil responsibility is based on the fact that a certain number of victims of medical accidents will not get compensation. The Supreme Court of Canada, in the Lapierre case (26) reminded us of this fact by citing with approval, a comment of the Court of Appeal judgment of Mr Justice McCarthy:

> "A mon avis, une obligation indépendante de toute faute dans des circonstances telles celles du cas présent, serait une excellente chose, mais notre droit actuel ne la prévoit pas." (27)

43.- A second initiative that could be taken by the courts, would be a clearer identification of causation. In general, but more specifically in medical matters, the case law should not make of the causation evaluation a simple matter of fact, without giving it some abstract and theoritical foundation. It is not good, in my opinion, to see the courts taking as a basis for solution in one case the "adequate cause", and in another, the "proximate cause" and yet, in another, the "condiction sine qua non" approach. This can only lead to unpredictability and the absence of an overall policy in tort law.

44.- A third area they may be ripe for judicial reform is that of informed consent. The Supreme Court of Canada may in the near future, have to refine its thoughts on the question. Many possibilities are open.

Should Canadian law look to the U.S. for guidance? Should it, on th contrary, in a way similar to the House of Lords in the Sidaway v. Board of Governors of the Bethleem Royal Hospital (28) reject the American model for a more conservative one?

45.- Finally, and more particularly in civil law, an effort must be made to define more clearly the legal relationship between hospitals and physicians. In civil law, professionalism and vicarious responsibility do not go together (29). This has forced the doctrine to insist on the contractual characteristics of the relationship, because if then allows the courts to hold hospitals liable for the negligence of the physicians they employ (30). In my opinion, this area, is ripe for reform. The concept of "professional vicarious liability" should be investigated (31).

46.- As far as the damages assessment process is concerned, a number of rules could be changed under the various provincial laws, if one takes the American experience as an guide.

47.- Some provinces have totally abolished (Quebec) or in part (Ontario) jury trials in civil or tort cases. For medical malpractice cases, this rule, I believe, is excellent. The sheer technicality and complexity of determination of fault and of damages evaluation are too sophisticated to be left to twelve ordinary citizens (32).

48.- Another reform concerns punitive or exemplary damages. I personally believe they should be totally abolished. Despite the common

law tradition to the contrary (33), we should revert to the main or real purpose of tort law which is compensation and not retribution. Punishment under one form or another should be left to criminal courts and disciplinary boards. The abuse of punitive damages awards in the United States is such that it has created an enormous inflation of the sums awarded to the victims. This is a model that we should not follow. In Quebec, punitive damages can now be awarded in a limited number of cases (34). The Civil Code Revision Commission moreover has suggested that their practice be generalized in cases of intentional fault (35). This policy decision should be revised.

49.- Another area that deserves at least serious consideration is that of the modalities of payment of damages. In Canada, by tradition, a one time capital sum is awarded, unlike in other countries (especially in Europe) where periodic payments are the rule (36). It would be wrong to think that this latter system is necessarily the best. Yet, the practical success of structured settlements in Canada shows that there is at least food for thought in that respect (37). Why shouldn't we adopt a system that compensates the victim fully, and yet is substantially less expensive for the tortfeasor?

50.- Finally a certain number of other rules could also be questioned. Should for instance, the ceiling established by the Supreme Court on non-economic damages be lifted (38)? Should (and this will be discussed specifically in this symposium) the collateral source rule be abolished, and the courts be allowed to take in consideration insurance and other benefits to reduce the total award?

2) EVIDENCE AND PROCEDURAL RULES

51.- At a general level first, and taking into account the recent American experience, a good deal of thought should be given to alternative modes of resolution of conflicts in malpractice cases (39).

52.- There is no doubt that the present system of civil litigation is very expensive. In that respect, a number of American states have adopted various models of arbitration of disputes, with sometimes remarkable success (40). Arbitration is generally less formal, and more economical than regular court action. Rules of evidence and procedure are also relaxed, which gives a better chance for out-of-court settlements. Yet, this kind of experience is almost unknown in Canada. Canadian lawyers should at least give the matter some thought.

53.- As far as evidence rules are concerned, any practising lawyer, whether for the plaintiff of the defendent, will inevitably complain about the whole area of expert evidence. Often enough the plaintiff cannot find an expert who will accept to testify against a physician, because that expert knows full well that he could probably someday find himself in the same situation. Secondly, the costs of expertise are such that often parties will simply have to forego it. Finally, in an area as complex as medical malpractice, expertise should preferably be objective. Our adversary system, on the contrary, tends to make of it a partisan exercise. Law does not like nuances or uncertainty, but prefers answers that are black or white. Science on the other hand, deals mostly with

probabilities and in shades of grey. The whole of the law on expert testimony should be critically apparaised and simplified. Something should be done to cut the costs and to enhance the neutral character of expertise.

54.- A certain number of comments can also be made in regard to the practice of law. Contingency fees, in the U.S., have given rise to serious questions. In Canada (as we will hear in this symposium), this practice is certainly not encouraged are sometimes even completely prohibited. The economic impact of contingency fees on malpractice liability is real. Without going into the advantages and disadvantages of this system, it is clearly a question that deserves critical evaluation.

55.- Finally the American practice (practically non existent as yet in Canada) of frivolous, and abusive actions must be condemned. A certain number of American lawyers, aware of the general solvency of doctors, of their fear of publicity and of their vulnerability, do not hesitate to sue even where there is little or no chances of possible success, only in the hope of getting an out of court settlement. Recently, American Courts have reacted against this practice by condemning lawyers to the payment of damages or at least to all the court costs (41). This is indeed a heavy price to pay. Yet in Canada, we should avoid the use of medical malpractice as a blackmail technique. One would hope, in that respect, for a much stricter control the Bar disciplinary committees.

56.- Such are, in a very succinct and incomplete way, a number of reforms that should at least be contemplated if one wishes to keep the present system working, and to avoid a more aggressive therapy.

B. AGGRESSIVE THERAPY

57.- On this last subject I will make only a few brief remarks, not because the topic is uninteresting, but because it is so immense that one would really need to devote an entire symposium to it.

58.- Many Canadian provinces, for a variety of social and economical reasons, have created distinct systems of liability for certain traditional areas of tort law. This is particularly true of workman compensation and of traffic accidents. Canada has followed, in that respect, the exemple of other countries.

59.- The question then can be asked whether or not it would be desirable to have a separate system for medical malpractice. Should society, for instance, compensate victims of medical acts on a no-fault basis?

60.- This idea is not new. As far back as 1964 an American author Erhenzweig (42), made some timid suggestions to that effect. Since then, the idea has progressed and has been explored in greater depth by others (43). This discussion is good because it raises some fundamental issues of general social interest: Is it socially acceptable that a number of

victims of medical acts remain without compensation? Is the actual system of economic distribution of the risk of medical errors, just and equitable?

61.- On the other hand, I do not believe, that one can describe the present system (at an other level than a purely philosophical one) as significantly bad or unworkable. On the whole, it has not reached the somewhat caricatural aspects of American law practice. Cultural and legal differences with the U.S. make it improbable that the various provincial laws will ever reach a comparable situation. This is not however a valid reason to stop questioning our own system and to cease to be critical of it.

CONCLUSION

62.- "Is the present exposure to professional liability in health care cases, contrary to good medical care?"

This was the original question. After this incursion in both pathology and therapy it is time to try and to provide a diagnosis.

63.- The precise impact of legal rules on medical practice is extremely difficult to evaluate. There is little doubt that the fear of malpractice liability is indeed an important factor, conditioning medical practice both of physicians and hospitals. It is argued, for instance, that in Canada, the important number of caesarian births is partly due to obstetricians wishing to protect themselves against the high risks associate with natural childbirth.

64.- Development of medical malpractice has had both a positive and a negative effect on medicine.

65.- A positive aspect, in my opinion, are the rules concerning informed consent. By thightening the duty to inform, law has acknowledged as a fundamental value, the respect due to the human person. It has placed the patient at the very center of the decision making process, promoted a more interactive relationship between physicians and patients, which should benefit the medical profession as a whole. The medical relationship should become less authoritarian, and thus less prone to abuses of authority.

66.- The increased severity of courts towards professional negligence is also a positive factor. As the French proverb goes "Fear is the beginning of wisdom". The threat of liability, if only because of the publicity that usually surrounds these cases, may have, on the whole, a preventive impact on medical practice and help eliminate unacceptable behaviours or standards of unprofessional conduct.

67.- Finally the fact that victims can now hope to get adequate and reasonable compensation for their damages and should not remain an economic burden for society as a whole must also be put on the positive side.

68.- On the other hand, recent developments in medical malpractice have had some negative impacts. One is the soaring rise of health costs as a whole (a fact which of course is not due only to medical malpractice costs, but to a combination of other factors as well).

69.- A second potentially negative aspect is the danger of an extension of the practice of defensive medicine. To avoid civil liability, hospitals and physicians may be tempted to restrict medical practice to a conservative one and to eliminate risks attached to innovative therapy. This phenomenon has already been observed in the U.S.A. If generalized, it would deal a severe blow to intelligent and innovative scientific medical developments.

70.- A third danger both in terms of costs and medical practice is the unwarranted multiplication of clinical testing and consultation refer-

rals. A number of physicians who used to rely upon their personal diagnosis, now have their patients submitted to series of tests (sometimes really unnecessary) or sent for consultations to a number of specialists or super-specialists, in order to lessen the risk of error. It is not certain that, in the final analysis, this practice is in the best interests of the patient. It creates delays, increases the costs for the patient and society, and is reflective of a dilution of the sense of professional responsability.

71.- Finally the threat of malpractice liability has a very significant psychological impact on doctors in general and as a result, may affect medical practice as a whole. It might tend to destabilize professionals at an individual level. No doctor really likes to be singled out and publicly investigated for actions that he does not really feel guilty about and that he believes, could have been taken by several of his confrères. At a more general level, the threat may cause some doctors to get out of a number of specialized medical fields (obstetrics, neuro-surgery for instance) because of the high degree of risks involved. In this respect the law must try to achieve a very delicate balance between individual and general concerns.

NOTES

(1) For Federal Germany, see: D. GIESEN, "Civil Liability in the Field of Medicine", (1984) 4 Islam and Comp. L.Q. 14, p. 20 et s; for the U.S.A., see also The statistic cited in the Report of the American Bar Association, "Towards a Jurisprudence of Injury: the Continuing Creation of a System of Substantial Justice in American Tort Law", 1984 and of the American Medical Association, "Professional Liability in the 80's" - 1985. For Canada, see the annual reports of the Canadian Medical Protective Association.

(2) "Symposium sur l'indemnisation des victimes d'accidents de la circulation", (1974) 9 R.J.T. 139; W. FOSTER, "A Comment on the Mémoire du Barreau du Québec au Comité d'étude sur l'assurance automobile", (1974) 9 R.J.T. 47.

(3) See for instance: G. ROBERTSON, "Informed Consent in Canada: An Empirical Study", (1984) 22 Osg. H.L.J. 139 in which the author argues that Reibl c. Hughes is ignored by doctors and has had no impact on medical practice; P. DESCHAMPS et R. FARLEY, "L'évaluation des poursuites en dommages-intérêts contre les professionnels de la santé", (1981) Med. du Q. 47. For the U.S.A. see: L. WILLIAMS, "The Relationship Between Medical Malpractice and Quality of Care", (1975) Duke L.J. 1197; R. WILEY, "The Impact of Judicial Decisions on Professional Conduct: an Empirical Study", (1982) 55 Cal. L.R. 345.

(4) This increase however is very often exagerated: See the figures of the Canadian Medical Protective Association, in E. PICARD, Legal Liability of doctors and Hospitals in Canada, 2e éd., Toronto, Carswell, p. 347; J. GEEKIES, "The Crisis in Medical Malpractice: Will it Spread to Canada?", (1975) 113 Ca. Med. Ass. J. 327; see also: M. DUMONT, "La négligence médicale: symptômes et causes d'une crise", (1979) 47 Ass. 44.

(5) A. TUNC, La responsabilité civile, Paris, Economica, 1981, n° 149 et s., p. 114 et s. et J. PENNEAU, Faute et erreur en matière de responsabilité médicale, Paris, Librairie générale de droit et de jurisprudence, 1973. This distinction was also put forward by Lord Denning in Whitehouse v. Jordan, (1981) 1 All. E.R. 267.

(6) The same applies to common-law negligence "... the omission to do something that a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs would do, or doing something that a prudent and reasonable man would not do": Blyth c. Birmington Waterworks Co., (1856) 156 E.R. 1047, p. 1049. See: A. LINDEN, Canadian Tort Law, op. cit., supra, note 12, p. 83 et s.

(7) See: Wilson v. Swanson, (1956) 5 D.L.R. (2d) 113 (Supreme Court of Canada) et E. PICARD, Legal Liability of Doctors and Hospitals in

Canada, 2nd ed., Toronto Carswell, 1984, p. 239 et s. A. LINDEN, Canadian Tort Law, op. cit., supra, note 12, p. 145 et s.

(8) See P.-A. CRÉPEAU, "La responsabilité civile du médecin", (1977) 8 R.D.U.S. 25, p. 27 et s.

(9) See comments by M. TEPLITSKY et D. WEISSTUB on Hobson v. Munkley, (1976) 14 O.R. (2d) 575 (High Court) in (1978) 56 C.B. Rev. 121 and M. SOMERVILLE, "Legal Investigation of a Medical Investigation", (1981) 19 Alta L.R. 171.

(10) See A. BERNARDOT et R. KOURI, La responsabilité civile médicale, Sherbrooke, Presses de l'Université de Sherbrooke, 1980, n° 43 et s., p. 29 et s.; P.-A. CREPEAU, "La responsabilité civile du médecin", (1977) 8 R.D.U.S. 25, p. 38 et s.; R. BOUCHER, "Les présomptions de fait en responsabilité médicale", (1976) 17 C. de D. 317; A. MECS, "Medical Liability and the Burden of Proof; an Analysis of Recent Quebec Jurisprudence", (1970) 16 McGill L.J. 163.

(11) See H. HART et A. HONORÉ, Causation in the Law, Oxford, Clarendon Press, 1962 et A. HONORE, Causation and Remoteness of Damages, International Encyclopedia of Comparative Law, Möhr, Tübingen, 1983, vol. XI c. 7.

(12) A. LINDEN, Canadian Law of Torts, op. cit. supra note 12, p. 9 et s.; H. PICARD, Legal Liability of Doctors and Hospitals in Canada, op. cit., supra, note 7, p. 100 et s.

(13) McGhee v. National Coal Board, (1972) 3 All E.R. 1008 (House of Lords); ROBERTSON, "Overcoming the Causation Hurdle in Informed Consent Cases: the Principle in McGhee", (1983) 21 Un. of W. Ont. L. Rev.

(14) J.-L. BAUDOUIN, La responsabilité civile délictuelle, 2nd ed., Cowansville, Editions Y. Blais, 1985, n° 352 et s., p. 182 et s.

(15) Idem., n° 358 et s, p. 182 et s.

(16) Art. 1074 C.c.

(17) City of Kamloops v. Nielsen, (1984) 2 S.C.R. 2 Comments J. IRVINE, (1984) 29 C.C.L.T. 185.

(18) In general see: E. PICARD, "The Tempest of Informed Consent" in KLAR, Studies in Canadian Tort Law, 2nd ed., Butterworths, 1977, 129; D. SCALETTA, "Informed Consent and Medical Malpractice: Where Do We Go From There?", (1979) 10 Man. L.J. 289; S. RODGERS-MAGNET, "Recent Developments in the Doctrine of Informed Consent to Medical Treatment", (1980) 14 C.C.L.T. 61; A. PATERSON, "Informed Consent: the Scope of the Doctors Duty to Disclose", (1980) 40 R. du B. 816; "Legislating for an Informed Consent to Medical Treatment by Competent Adults", (1981) 26 McGill L.J. 1056; M. SOMERVILLE, "Structuring the Issues in Informed Consent", (1981) 26 McGill L.J. 673.

(19) Hopp v. Lepp, (1980) 2 S.C.R. 192; comments: J. IRVINE, (1980) 13 C.C.L.T. 69; D. FERGUSON, (1980) 1 Health 56; M. GOCHNAUER et D. FLEMING, (1981) 15 U.B.C.L. Rev. 475; G. SHARPE, (1981) 1 Health 79.

(20) Reibl v. Hughes, (1980) 2 S.C.R. 880; comments: S. RODGERS- MAGNET, (1980) 14 C.C.L.T. 61; E. PICARD, (1981) 19 Osg. H.L.J. 140.

(21) See the excellent study of R. KOURI, "L'influence de la Cour suprême sur l'obligation de renseigner en droit médical québécois", (1984) 44 R. du B. 851 et L. POTVIN, L'obligation de renseignement, Cowansville, Editions Yvon Blais, 1984.

(22) P. OSBORNE, "Causation and the Emerging Canadian Doctrine of Informed Consent to Medical Treatment", (1985) 33 C.C.L.T. 131; E. PICARD, "Informed Consent Takes Shape", (1983) 24 C.C.L.T. 250.

(23) Sunne v. Shaw, (1981) S.C. 609; Schierz v. Dodds, (1981) C.S. 589.

(24) See G. VINEY, Traité de droit civil: La responsabilité: conditions, Paris, Librairie générale de droit et de jurisprudence, 1982, n° 278 et s., p. 341 et s.

(25) Andrews v. Grand and Toy Alberta Ltd., [1978] 2 S.C.R. 229; Thorton v. Board of School Trustees of School District n° 57, [1978] 2 S.C.R. 267; Arnold v. Teno, [1978] 2 S.C.R. 287. For wrongful death see Lewis v. Todd, [1980] 2 S.C.R. 694.

(26) Lapierre c. Procureur général du Québec, (1979) C.S. 907; (1983) C.A. 631, [1985] 1 S.C.R. 241.

(27) Lapierre v. Procureur général du Québec, [1985] 1 S.C.R. 241, p. 263.

(28) Sidaways v. Board of Governors of the Bethleem Royal Hospital, (1984) 1 All E.R. 1018; (1985) 2 W.L.R. 480 (House of Lords); G. ANNAS, "Why the British Rejected the American Doctrine of Informed Consent", (1984) 74 Am. J. of Pub. H. 1286.

(29) J.-L. BAUDOUIN, La responsabilité civile délictuelle, op. cit., supra, note 14, n° 512 et s., p. 254 et s.

(30) P.-A. CRÉPEAU, "La responsabilité civile de l'établissement hospitalier en droit civil canadien", (1981) 26 McGill L.J. 673, D.

(31) See A. LAJOIE, P. MOLINARI et J.-L. BAUDOUIN, "Le droit aux services de santé: légal ou contractuel?", (1983) 43 R. du B. 675; D. CHALIFOUX, "Vers une nouvelle relation préposé-commettant", (1984) 44 R. du B. 815. For common law see J. MAGNET, "Vicarious Liability and the Professional Employee", (1978) 6 C.C.L.T. 208; E. PICARD, "The Liability of Hospitals in Common Law Canada", (1981) 26 McGill L.J. 997.

(32) See M. TEPLITSKY et D. WEISSTUB, "Torts, Negligence Standards and the Physician", (1978) 56 C. B. Rev. 121; W. BOGART, "The Use of Civil Juries in Medical Malpractise Cases", in Studies in Civil Procedure, 1979, p. 1.

(33) G. FRIDMAN, "Punitive Damages in Torts", (1970) 48 C. B. Rev. 373; L. HAWLEY, "Punitive and Aggravated Damages in Canada", (1980) 18 Alta L. Rev. 485.

(34) Charte des droits et libertés de la personne, L.R.Q. 1977, c. C-12, art. 49.

(35) Projet de l'Office de révision du Code civil, (1977) art. V-290.

(36) Such is the case in France. See Y. CHARTIER, La réparation du préjudice, Paris, Dalloz, 1983.

(37) N. FOSTER, "Structured Settlements", (1982) 20 Alta L. Rev. 434; J. WEIR, "Structured Settlements", Toronto, Carswell, 1984.

(38) Some U.S. states have even had a legislative intervention on the subject.

(39) See D. WARREN, Recent Developments in the Field of Medical Malpractice Law and Policy in the United States, International Conference of the American Association of Law and Medicine, Sydney, Aug. 1986 (unpublished).

(40) See D. WARREN, op. cit., supra, note 38. G. SHARPE, "Alternatives to the Court Process for Resolving Medical Malpractice Claims", (1981) 26 McGill L.J. 1036.

(41) North Carolina: N.C. Gen. St. 6-21 5 (1984) passed a law allowing courts to condemn lawyers to all the costs in case of "... a complete absence of justiciable issue of either law or fact..." A number of doctors have taken to sue lawyers for malicious prosecution. See: D. SOUOL, "The Current Status of Medical Malpractise Countersuits" (1985) 10 Ann. J. Law and Med. 439.

(42) A. EHRENSZWEIG, "Compulsory Hospital: Accident Insurance: a Needed First Step Towards the Displacement of Liability for Medical Malpractice", (1964) 31 U. of Chic. L. Rev. 279.

(43) For instance: H. ROOT, "Medical Malpractice Litigation: Some Suggested Improvements and a Possible Alternative", (1966) 18 U. of Flo. L. Rev. 623; J. HAINES, "The Medical Profession and the Adversary Process", (1973) 11 Osg. H.L. 41; D. KRETZMER, "The Malpractice Suit: Is it Needed?", (1973) 11 Osg. H.L.J. 55; G. HAVIGHURST and N. TANCREDI, "A No Fault Approach to Medical Malpractice and Quality Insurance", (1974) 613 Ins. L.J. 69; G. CALABRESI, "The Problem of Malpractice: Trying to Round Out the Circle", (1977) 27 U. of T. 131.