The prevailing perception of crisis in North American health care caused by the extent and consequences of medical malpractice litigation repeats a sense of danger to medical practice and public health care that was seen in the mid-1970s. Originating in the United States, that too raised speculation about its applicability to Canada. The concern is not new, since more than a century ago it was observed that '[l]egal prosecutions for malpractice in surgery occur so often that even a respectable surgeon may well fear for the results of his surgical practice.' The belief was expressed, often heard at the present time, that some practitioners were stopping their medical practices because of the threat of malpractice suits. In recent years, however, respected commentators have observed 'an exponential rise in litigation' that has been seen to have spread to Canada. In 1985, for instance, the president of the Canadian Hospital Association wrote that:

Until recently, Canadian court judgments pertaining to medical malpractice had not completely followed the trend in the United States. However, the situation is now reaching alarming proportions with recent judgments allocating substantial awards and an increase in the number of malpractice suits.

This study of the 'alarming' effects in Canada of legal liability on
health care providers will deal with physicians, and consider other health care providers only by inference when their activities depend on physicians’ initiatives. Second, it will not directly consider the legal liability of hospitals that may arise through their interactions with physicians.\(^6\) Third, it will consider only civil liability, and will not address the potential criminal liability of physicians.\(^7\) The study will also treat ‘legal liability’ as a euphemism for malpractice liability, and treat malpractice as being centred on negligence, in accordance with medical, professional, and popular usage, although in law malpractice may be distinguishable from negligence. Indeed, in Ontario the Health Disciplines Act speaks of ‘negligence or malpractice,’\(^8\) adverting to such civil wrongs other than negligence as battery, breach of contract with a patient and, for instance, breach of fiduciary duty. This historical language\(^9\) has not been comprehensively defined or distinguished, and ‘malpractice’ will be used here for general description rather than definition. In the leading case of Boase v. Paul\(^10\) the word ‘malpractice’ was considered to describe

mistakes, negligence, or improper treatment of a patient if the cause of action arose out of or in the course of professional services either requested or rendered under an implied contract, or under a mistaken interpretation of that express or implied contract.\(^11\)

The emergence of provincial health insurance plans in Canada has not displaced the contractual basis of health care where physicians are remunerated on a fee-for-service basis. The fact that a provincial plan pays the fee and determines its level is of no legal consequence to the physician-patient contract, although this is more apparent when an ‘opted out’ practitioner bills the patient directly and the patient is then reimbursed by the provincial health insurance plan. Salaried physicians may be different, however, in that their legal relations with patients do not

\(^6\) The law on hospital liability is addressed in the paper for the Prichard Review by Bruce Chapman Controlling the Costs of Medical Malpractice: An Argument for Strict Hospital Liability.

\(^7\) See generally the Law Reform Commission of Canada, Report 28 Some Aspects of Medical Treatment and Criminal Law (1986).

\(^8\) RSO 1980 c. 196 s. 17

\(^9\) Traceable to 1887 in An Act to Amend the Ontario Medical Act, 50 V c. 24, s. 2

\(^10\) [1931] 4 DLR 435 (Ont. CA)

\(^11\) Per Hodgins JA, at 437. In Winn v. Alexander (1946) OWN 238 (Ont. HC) Urquhart J treated ‘negligence or malpractice’ as excluding ‘deliberate or intentional assault’ (at 241) but did so inconclusively. Hadley v. Allore (1987) 63 OR (2d) 208 (CA) confirmed that ‘malpractice’ includes medical battery.
originate in contract law but in obligations imposed primarily by tort law.\textsuperscript{12} That law governs liability for negligence and, for instance, assault.\textsuperscript{13}

The purpose of this study is to apply to principal claims about the consequences on the practice of medicine of physicians' liability to be sued, and to be held liable, the empirical data generated in mid-1988 by the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care, chaired by Dean J. Robert S. Prichard (herein-after, the Prichard Review). Conscious of the lack of contemporaneous empirical Canadian information, the review sponsored surveys of the effects of legal liability on two medical specialties that are apparently particularly vulnerable to suit, namely, anaesthesiology and obstetrics and gynaecology, and for comparison on practitioners of general and family medicine. The latter area of study was valuable not only for contrasting the former high-risk medical specialties with traditionally low-risk practice, but also for observing the impact of liability on the practice of anaesthesiology and obstetrics and gynaecology by rural and suburban general and family practitioners, who have been accustomed to undertake such practice in local hospitals on a part-time or occasional basis.

Briefs submitted by national and provincial medical associations identified alleged effects of liability, and were invaluable in presenting the medical profession's perceptions of the extent and effect of practitioners' liability to be sued and to be held in breach of legally set standards. They fitted into a wider, historical context of medical professionals' responses to the impact of legal doctrine and procedures on medical practice, and on the quality and convenience of health care available to patients.

CAUSES OF MEDICAL MALPRACTICE LITIGATION
A study of the claimed effects of the increase in medical malpractice litigation cannot be detached from consideration of alleged causes of litigation. At several points, indeed, the relation of cause and effect is so unclear that commentators on related phenomena offer diametrically opposed interpretations. Some propose, for instance, that poor commu-

\textsuperscript{12} Equitably founded fiduciary duties are also apparent in aspects of physicians' duties; see Kenny v. Lockwood [1932] 1 DLR 507 (Ont. CA).
\textsuperscript{13} In Rebl v. Hughes (1980) 114 DLR (3d) 1, the Supreme Court of Canada confirmed that failure to give a patient adequate information for legally effective consent to treatment is to be assessed under the law of negligence, and that liability for assault will be limited to treating a person without consent or in excess of consent.
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communication by physicians with patients exposes them to litigation, whereas others claim that fear of liability to suit induces physicians' guarded discussion and poor communication. At a wider level, some attribute the potential for adversarial conflict to the erosion of the traditional physician-patient relation, and others blame patients' litigiousness for physicians' inability to maintain the familiarity and assumption of accountability for patients' well-being of earlier times. A number of alleged causes of the modern increase in medical malpractice litigation are incompatible with others, but they will briefly be set out in order to indicate perceived origins of the rise in patients' willingness and capacity to sue.

The claims that doctors are not as good as they used to be and that, on the contrary, doctors are better than they used to be, are not necessarily incompatible explanations of litigation, because they use different criteria of good doctoring. The former claim related to the old-style family doctors who knew and cared for their patients as persons, and were friends of the families they served. Their professional skills may have been no more than ordinary, but their skills in comforting patients and their authentic concern for patients' well-being were acknowledged. Disappointing results of care were mutually distressing but, as friends of the patients, they were neither blamed nor sued. Modern doctors do not know patients as personally, nor tend to their needs as fully. The latter claim relates to modern, proficient medical specialists in large, well-equipped metropolitan hospitals, often university-based, who achieve high levels of success in treatment. Their well-publicized successes induce unrealistic expectations in patients that every condition can be remedied. When a remedy fails to materialize, doctors are blamed, because treatment failure is attributed to their personal shortcomings rather than to any systemic limitation of the capacity of medical science. The hospital environment is also perceived to be alienating, disposing dissatisfied patients to sue specialist members of multidisciplinary treatment terms in order to assert individuality and gain attention on their own terms.

Physicians often explain increased litigation in terms of features of the

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14 This is a frequent theme in annual reports of the CMPA.
15 See further the text below on Claimed Effects of Liability to Suit.
16 This is the first possible cause of the increased volume of litigation proposed in the New Brunswick Medical Society's submission to the Prichard Review, at 1.
17 See further the text below on Validity of Claims of Effects.
18 The need to educate the public regarding the limitations of medical science was the theme of many responses by practitioners to the three questionnaires.
organization of the legal profession, manipulation of the courts, and developments in legal doctrine and process. Legal aid schemes are seen to support unjustified litigation, and lawyers acting on contingency fees are believed to pursue claims aggressively out of material self-interest. Courts are seen to allow specious claims in order to provide compensation to plaintiffs that is unobtainable by application of regular tests of liability for negligence. Legal doctrines are observed to encourage plaintiffs by facilitation of their actions, such as by pro-patient legal rules on informed consent and establishment of negligent causation of injury by the res ipsa loquitur rule. Rules on pre-trial discovery of documents are seen to favour plaintiffs, including the lack of immunity of records of hospitals' risk management and peer review committees, and plaintiffs' lawyers are claimed to use coroners' inquests and charges of professional misconduct before licensing authorities' disciplinary committees to find or create materials helpful to their clients. Limitation periods may also have been extended by statutes or judicial construction, in order to allow initiation of proceedings for longer times than used to be applicable, and courts allow presentation of extravagantly assessed claims for trivial causes, creating a snowball effect when publicized to other potential plaintiffs, who also seek unrealistically large awards.

As against these alleged reasons for the increase in the number and size of medical malpractice claims, a series of contrasts may be drawn with the US position in order to explain why claims in Canada have been relatively few. The social security, health insurance, and unemployment insurance schemes reduce the need for individuals to seek com-

19 Although in some provinces, the legal aid scheme does not cover medical malpractice claims; the brief to the Prichard Review by the Medical Society of Nova Scotia commented on the hardship this causes impecunious patients, at 8.
20 Ontario is the only province that does not permit contingency billing. When the Law Society of Upper Canada responded to a perceived over-supply of law graduates by considering permitting contingent fees, the Ontario Medical Association voiced powerful opposition.
21 Judges dismissing plaintiffs' claims sometimes say that they consider the outcome to be socially unjust; see Linden J in Davidson v. Connaught Laboratories (1980) 14 CCLT 251, and Krever J in Ferguson v. Hamilton Civic Hospitals (1983) 40 OR (2d) 577.
23 The Canadian application of this doctrine is in fact quite strict; see Hobson v. Munkley (1976) 74 DLR (3d) 408 (Ont. HC).
24 An analysis of 2,784 liability claims brought against members of the California Hospital Association between 1969 and 1972 showed that the damages claimed were on average 53 times greater than the damages eventually recovered; see Report of the Secretary's Commission (US Secretary of Health, Education and Welfare) on Medical Malpractice Medical Malpractice (1973) 38 n19.
25 For a slightly dated but interesting review, see R. Welch 'Medical Malpractice in Canada' ibid. appendix 849.
pensation for medical injury. The judicially imposed ceiling on general damages\(^{26}\) limits speculative claims,\(^{27}\) and courts have been slow to allow punitive or exemplary damages. The Canadian Medical Protective Association (CMPA) represents almost all doctors at risk of suit, and rather than settle a claim believed to be vexatious, frivolous, or misconceived, the CMPA will fight it and appeal a decision if necessary without regard to the expenses, which are seen to be a good investment in deterring litigation against members. Unlike in the United States, where courts do not award successful litigants recovery of their legal costs except in a limited (but expanding) number of circumstances, unsuccessful litigants in Canada are usually ordered to pay legal costs of the defendants. Further, jury trial is rarely ordered in a medical malpractice case involving medical or scientific evidence, whereas that form of trial is common in the United States because of plaintiff's constitutional guarantees.\(^ {28}\)

**Claimed effects of liability to suit**

The medical profession customarily identifies a number of consequences that flow from physician's liability to be sued and to be held liable in cases where medical defendants are considered to have behaved competently and conscientiously according to professional standards. The major effects of such liability to suit are expressed as costs to the public, notably in the waste of scarce resources through the practice of defensive medicine, and in the waste of therapeutic skills that occurs when physicians withdraw from areas of practice, which itself may be a form of defensive medical practice. The stress of litigation to individual defendants and their related loss of morale are also recognized, often as injuries in themselves but sometimes as leading to defensive medicine and to partial or total withdrawal from practice, through early retirements, for instance, or through adoption of non-practicing medical careers. A number of these claims will be explored before evidence of their validity is reviewed.

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26 See *Andrews v. Grand & Toy Alberta Ltd.* (1978) 83 DLR (3d) 452 (SCC) at 478. In this case the Supreme Court of Canada set an upper limit for non-pecuniary damages at $100,000; because of inflation, this is now applied as a limit of about $220,000.
27 In Ontario the subrogation practice of the health insurance plan may lead to litigation in order for the plan to retrieve its expenses caused by injury.
28 Further, legislated limits on recovery of general damages in medical malpractice claims in the United States are frequently held unconstitutional in the courts, usually for violation of guarantees of equal protection; see D. Giesen *International Medical Malpractice Law* (1988) 496-501.
DEFENSIVE MEDICINE
The expression ‘defensive medicine’ tends to be applied indiscriminately to a variety of medical practices conditioned by fear of patients’ litigation. A deliberate change of medical practice designed to reduce liability to be sued may introduce a distortion into a physician’s preferred mode of practice and interaction with patients, and may be considered an unwelcome intrusion into professional judgment. A change in practice designed to reduce legal liability by observance of a rule or standard that has been judicially endorsed may appear to be conformity to the law, however, and achieve the demonstrative effect the courts intend through discharge of their standard-setting function.

A distinction has been drawn between ‘positive defensive medicine’ and ‘negative defensive medicine.’ The former is typified by the over-use of diagnostic and treatment procedures that are medically unjustified, by expanded record-keeping, and by the use of extra tests or time for discussion. The latter is represented by procedures or activities that a physician refuses to undertake because of a fear of a later malpractice suit when a patient may benefit from the procedures or activity. The almost invariable use of the expression ‘defensive medicine’ by the medical profession and the wider public in a derogatory sense tends to obscure the distinction between undesirable and desirable effects of fear of suit or of liability. Further, the derogatory use biases interpretation of responses to fear of suit. It may appear undesirable, for instance, that general medical practitioners in rural areas should withdraw from the occasional hospital practice of anaesthesiology, for such reasons as insufficient cases to maintain required standards of proficiency or to justify payment of the higher fee paid by members of the CMPA who practice in this field. An alternative interpretation of such an effect of fear of suit is that surgery patients are more likely to receive anaesthetic services from full-time specialists, although at greater cost to local hospitals or to patients receiving care far from where they live.

Costs to the public in health insurance plan payments for unnecessary tests and in inconvenient treatments were emphasized in the national

29 Requirements of medical practice are rarely established by courts in the abstract, but judges commonly declare their preference of styles of practice that expert medical witnesses have testified were appropriate in the circumstances of given cases.
32 See the text below on Validity of Claims of Effects.
33 See the text below on the interaction of quality and convenient accessibility of health services.
and provincial medical associations' briefs submitted to the Prichard Review. Frequently cited examples of positive defensive medicine include:

- excessive use of x-ray and routine diagnostic procedures;
- excessive use of laboratory tests of blood, urine, tissue, and related samples;
- use of available technologically advanced diagnostic equipment in unproven circumstances;
- additional office or hospital visits to follow medical conditions that may give rise to complications;
- excessive use of medical second opinions and consultations with specialists;
- more hospitalizations for borderline cases that might have been treated as well through out-patient, office-based or home-based care; and
- extended hospitalization of patients following surgical and non-surgical care, to avoid premature discharge and possible complications during home recovery.

Although defensive medicine is commonly claimed to exist, and is indeed sometimes perceived to be ubiquitous, it has proven impossible to quantify. Claims of its practice are substantiated in physician's anecdotal revelations of their own practices, but no estimates are offered of the collective incidence of such practices and their costs to the national and provincial health care systems. The problem of making assessments is compounded by the uncertainty about where good medicine stops and purely defensive medicine begins. It has been observed that 'the same practice or procedure which one physician claims he employs solely for medico-legal (i.e., defensive) reasons may be employed by a substantial number of other physicians because they believe it to be the appropriate treatment in the given circumstances.' 34 The very distinction between legally and therapeutically indicated procedures is cast in doubt by the observation that 'medical professionals agree that the element of legal threat may add to their own or their colleagues' estimate of the clinical value of diagnostic or therapeutic procedures.' 35

An interesting feature of the Canadian Medical Association's brief to the Prichard Review was its reliance for factual data on materials published in the Report of the Secretary's Commission on Medical Malpractice, published by the US Department of Health, Education and Welfare in 1973, during the so-called first wave of the 'medical malprac-

34 E.P. Bernzweig 'Defensive Medicine' in Report of the Secretary's Commission, supra note 24, appendix 38, at 39
35 Canadian Medical Association brief to the Prichard Review (1988) at 40
36 Now the Department of Health and Human Services
A study prepared for the 1973 report noted that ‘a number of formal and informal surveys of physicians have indicated that between 50 and 70 percent of all physicians claim that they practice defensive medicine of one sort or another with varying degrees of regularity.’ The study appears to have influenced the report’s finding, however, that ‘defensive medicine is practiced, but the extent to which it is practiced is not known. It does increase the cost of medical care, but it is doubtful that the increased cost is measurable.’ The brief to the Prichard Review from the Medical Society of Nova Scotia spoke in its opening sentence about ‘the cost of defensive medicine, which in the U.S. is estimated to be approximately 15 billion dollars per year.’ While almost all medical professional submissions to the review acknowledged the practice of defensive medicine, no estimates of its incidence or cost in Canada were offered.

A possible measure of one aspect of defensive medical practice may consist in identification of diagnostic tests that are ordered and conducted but whose results produce no alteration of or influence on the way the ordering physician originally proposed to treat the patient. A test may be valuable, however, even though it provides no reason why the physician should not proceed in the way initially proposed, because conduct of the test may reduce the incidence of iatrogenic (physician-induced) injury through the performance of a contraindicated procedure. The assessment whether the cost of an additional test is justified by the additional margin of safety it produces in conduct of a procedure relies on medical professional judgment, which is unlikely to be faulted by the courts provided that the physician applies relevant clinical criteria and surrounding knowledge. In the United States, where patients pay for such tests, there is little evidence that patients’ informed choice on whether or not to have additional tests results in marginal tests not being performed.

The Society of Obstetricians and Gynaecologists of Canada noted in its brief that the society is looking at the question of taking cord blood samples at birth for all babies, which is not necessarily useful in their management, in order to show that babies were not asphyxiated at the time of birth. The society also commented on an ‘increasing demand

37 Supra note 34
38 Supra note 24, 39
39 On the distinction between error of judgment, which does not lead to legal liability, and unskilfulness due to lack of knowledge, see Wilson v. Swanson [1956] 5 DLR (2d) 113 (SCC) at 120.
40 SOGG position paper, at 14
for technology in rural hospitals even though there is no evidence that for low risk obstetric cases ... this will improve outcome."41 A cost of defensive medicine may be the purchase of costly equipment. The Canadian Anaesthetists' Society brief observed of its questioned members that '[t]he majority felt that the threat of liability made it easier to obtain funding for appropriate equipment; indeed, in many cases, it was this pressure alone that decided in favor of purchase.'42 Pressure to purchase 'appropriate' equipment may, however, be unobjectionable. The sting of defensive medicine is pressure to purchase or use inappropriate means.

REDUCED ACCESS TO SERVICES

Excessive health care costs due to defensive medicine may limit the number of services a province can fund, but a direct cost to patients (as opposed to provincial treasurers) of medical professional responses to legal liability is claimed to be that they receive reduced access to care. This may be expressed in unavailability of physicians when and where patients seek them, and in unavailability of medical procedures from which patients' diagnosis, treatment, or monitoring may benefit, due to practitioners' fear of suit. Physician's refusals to undertake what they believe to be high-risk procedures have also been described above as 'negative defensive medicine.'43

Patients' access to conveniently available services may be obstructed by fear of suit that leads to such behaviour as:

- physicians limiting their practices to serving low-risk patients, meaning those at low health risk to suffer injury, but possibly including the delivery of care only to patients who understand the uncertainty of medical prognosis and do not have unrealistically high expectations of successful outcomes of medical procedures or treatments;
- physicians changing their specialties away from those believed to attract litigation, or physicians in the practice of general and family medicine declining to perform services in obstetrical care, anaesthesia, or, for instance, emergency care;
- physicians taking early retirements from practice, or leaving patient care and applying their skills in administrative or research occupations or in similar careers not involving care of patients;
- medical students or newly qualified practitioners selecting their specialties so as to escape those believed to be prone to malpractice claims; and

41 Ibid. The cost of an electronic fetal monitor was estimated at $14,000.
42 CAS discussion paper, at 5
43 See the text at supra note 31.
• physicians in general or specialized practice declining to perform procedures or recommend treatments believed to be unduly liable to risk injury to patients, or to frustrate patients' expectations of safe and effective outcomes.

Claims that physicians were withdrawing their services in whole or in part appeared in all of the briefs submitted to the Prichard Review. Some approached the matter from the perspective of physicians, pointing to their loss of satisfaction with their work, their pursuit of career alternatives, and the psychological stress of engagement in litigation. Others assessed the impact of malpractice suits on patients' access to convenient services and a full range of treatment options. Several linked loss of practitioners to safety of patient care, in that, if fewer practitioners bear the caseload of patients, they may deal with cases too quickly,\(^44\) or work long hours with related fatigue and liability to error.\(^45\) Some medical services must be timed more to suit the patients' needs than the physician's preference or availability, particularly obstetrical services. The brief from the Society of Obstetricians and Gynaecologists of Canada noted 'a shortfall of 240 obstetricians/gynaecologists in Canada as of December 1986,'\(^46\) and that:

In conjunction with early 'retirement,' and potential manpower shortages, trends in recruitment become critical. Information from the Canadian Interns Matching Services (1987 for 1988) shows that the total number of positions available were 48 positions and 41 were suited by Canadian graduates. The interest of residents has been seriously affected by the new poorly accepted perceived life style of the OB/GYN but particularly by the likelihood of being involved in a 'malpractice suit.'\(^47\)

This brief also adverted to a cost of loss of experienced specialists that may be generalizable to other medical specialties. The increased number of caesarean section deliveries was attributed (at least in part) to the loss of older obstetricians who are experienced in manipulative skills required for the non-surgical management of breech deliveries and delivery of a second twin.\(^48\) Their premature departure from the specialty leaves such cases in the hands of less experienced personnel who turn for safety to surgery, with its attendant risks, for instance of anaesthesia.

\(^{44}\) Either by prescribing treatment, perhaps on inadequate consideration of data, or by referring patients to consultants, perhaps prematurely or unnecessarily  
\(^{45}\) See, for instance, the discussion paper presented to the Prichard Review by the Canadian Anaesthetists' Society, at 17.  
\(^{46}\) SOGC position paper, at 6.  
\(^{47}\) Ibid. 6–7  
\(^{48}\) Ibid. 14
Patients thereby lose access to alternative forms of management, and the autonomy implicit in choice. Patients are not left to unskilled care, but the medical services on which they can draw are impoverished and their own preferences of delivery cannot be easily accommodated.

A concern related to patients' lack of access to good quality services is that medical-school professors and clinical instructors in hospitals may so fear liability to patients whose care they supervise when it is undertaken by medical interns and residents that they will limit such trainees' clinical activities. Entrants to medical practice will thereby be denied exposure to the experience of patient care, and to assumption of direct responsibility for rendering information and care to patients. The Royal College of Physicians and Surgeons of Canada addressed a brief to the Prichard Review, 'The Potential Effect of Liability on Post-graduate Medical Education in Canada,' which expressed the fear that:

Teachers and teaching hospitals, uncertain in the ever changing climate of liability risk, may compromise the preparation of specialist physicians by limiting the clinical activity of interns and residents ... The fundamental concept of clinical education is a continuum of increased clinical responsibility under supervision permitting a smooth transition from junior to senior levels of training and subsequently to independent medical practice.49

The college's fear that trainees would forfeit proper training through experience under supervision was coupled to a fear that they would also learn inappropriate attitudes. The college summarized its position as follows:

Clinical teachers and teaching hospitals must not have their capability to provide high-quality postgraduate medical education compromised by undue fears of liability. Nor should today's trainees, tomorrow's practicing physicians, have as role models clinical teachers whose practice is based on fear of liability rather than on sound clinical judgment.50

THE EMOTIONAL COSTS OF MALPRACTICE LITIGATION

It has been seen above that the impact of liability to suit is claimed to strip physicians of personal satisfactions gained from their work, and to cause them to pursue alternative careers that do not involve interactions with patients or others they fear are likely to sue them without cause. The claim to emotional injury is often reinforced through the obser-

49 Royal College of Physicians and Surgeons of Canada brief, at 7.
50 Ibid. 8; see also D.R. Challoner, K.E. Kilpatrick et al. 'Effects of the Liability Climate on the Academic Health Center' (1988) 319 New England J. of Med. 1603.
vation that fear of litigation undermines physicians' self-confidence, and that suspicion that patients seeking and perhaps achieving cures will still sue them, because of some perception of minor insult or dissatisfaction, corrodes practitioners' professional morale.51 The allegation of emotional injury transcends the natural disappointment, frustration or anger, and feeling of betrayal that may be felt when a patient who was considered a friend, and to have been competently and conscientiously treated, behaves unreasonably about some actual or perceived failure or slight. The claim made is that physicians are emotionally scarred not by theoretical liability to suit, but by actually being served with a writ, having to endure the pre-trial processes preparatory to appearance in court, and having to appear in court and be publicly examined, cross-examined, and doubted regarding their exercise of the skills through which they identify themselves and have esteem in their own eyes.

Acknowledgment of litigation trauma and compensation neurosis is made in the general field of personal injury litigation,52 where at judgment, courts may reflect on the emotional burden the litigation has cast, particularly on the successful party. This factor may influence not only the award and level of legal costs but also the level of damages recovered by a successful plaintiff. In medical malpractice cases, of course, physicians will be defendants, so that only an award of costs may be available to recognize what emotional injuries they have been caused unjustly to suffer. Damage to a defendant's ego and enjoyment of life comes not simply from preoccupation with the complaint, but from having to become familiar with legal processes and language. The physician, normally masterful and self-confident in the setting of medicine, becomes infantilized in the setting of adversarial litigation and liable to feel powerless and at the disposal of others. Lawyers appointed by the CMPA represent the defendant physician, and, while acting conscientiously, they may not afford the defendant the control other defendants may feel when they 'instruct counsel' of their own choice. Feelings of incomprehension, alienation, outrage at the opponent's distortions, and fear about an arbitrary and unjust outcome can understandably cause distress, which at times may reach pathological levels.


52 See the UK Royal Commission on Civil Liability and Compensation for Personal Injury (Chairman: Lord Pearson) Report vol. 1, cmd 7054-1 (1978) at 63, paragraph 252.
Anecdotally, one physician from British Columbia has recorded the emotional experience of being sued. He observed that:

First of all, I experienced 'denial' ... Often I pushed the problem right out of my consciousness ... A nasty part of the denial reaction was the way it scrambled up my memory of the events so that what I believed had happened did not actually happen in many details ... Worse still, it blinded me to the fact that I was blameless, my colleague as well.

The part which was very hard to take was that I felt very badly about myself and my fitness to act as a physician. I lost faith in my judgment. I became anxious and unsure in my dealings with patients, mistrusting what they were saying to me, losing my discrimination when examining them, over-utilizing investigations, and being hesitant in arriving at a working diagnosis.

I felt 'anger.' [The plaintiff] refuses to take responsibility for his own [contributory] actions ... I perceive that the legal system and the medico-legal climate encourage him in his irresponsibility. But, at the same time, I am angry at myself for missing that complication. Despite all the other factors that excused the omission, as I believed it, I felt reprehensible and lost further faith in my judgment.53

The physician was found not liable, and it is to be hoped that his self-confidence and professional attributes soon returned. A patient might not be blamed, however, for not wanting the defendant to treat him or her during the litigation, not because the physician might be found liable and proven to be a negligent physician, but because even if he was not liable he would be impaired in his professional capacities while suffering the emotional effects of the proceedings. This perception may give substance to the claim that prospective patients have an interest in knowing the identities of physicians who are being sued or who are facing disciplinary charges of professional misconduct. The response, particularly in the latter case, that this stigmatizes the innocent, does not address the perception that the burden of the charges may render them unsuitable practitioners.

This anecdotal narration of a legal suit inducing feelings of denial, confusion of events, self-blame, anger, unworthiness, hesitancy, and insecurity is graphic not simply in itself, but also because it is so closely identifiable with the grief reaction following bereavement. It appears that being sued may be like suffering a death in the family, the more stressful because the death may be sensed to be of the defendant's self-

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image, self-esteem, and self-confidence. Further, as in the case of those whose loved ones face death, there may be an experience of anticipatory grief when a physician apprehends that suit is imminent, and a writ is liable to be served. Lawyers may understand that writs are issued and perhaps even served in order to meet limitation periods for the commencement of action, lest liability may be incurred for legal malpractice in failing to initiate proceedings in time against a party who may in theory be liable to a client. Writs may be issued and served on the shotgun principle of covering a large area in the hope of hitting the target with one of many discharged pellets. Marginal defendants who are caught in the breadth of the blast may be inconsequential to lawyers and plaintiffs, and easily discharged from progress of the proceedings. The impact of inclusion on the defendant, however, may be calculated not simply in terms of legal strategies and expenses, but also in terms of emotional costs.

ASSOCIATED EFFECTS OF LIABILITY
Different ways of interpreting or expressing a widely claimed effect of liability, namely, defensive medicine, may appear to present a separate consequence of fear of suit. The claim that fear of liability leads to an irrational use of resources is based on the experience that physicians may become acutely sensitive to patients' requests for diagnostic tests, treatments of therapeutic potential, and means or intensities of monitoring of treatments. They therefore order tests or undertake treatments or monitoring not because they consider them indicated by the patients' conditions or beneficial to patients, but in order to forestall litigation. Patients with comparable conditions are treated differently, depending on whether they ask for diagnosis or care that exceeds what physicians assess to be appropriate. In relation to patients' medical circumstances, their different methods of management appear irrational. If available resources for patients were governed by their presenting conditions, like cases would be treated in like ways, and at like cost. As against this, however, it may be claimed that patients are not alike merely because they have comparable presenting conditions but are authentically distinguishable by reference to their acceptance of physicians' recommendations of care and, in contrast, their requests for additional diagnosis, treatment, and follow-up care.

More substantive is the claim that fear of suit and courts' suspicions of physicians' departures from orthodox means of diagnosis, treatment, and, for instance, monitoring of treatment reinforce unduly conservative patterns of practice and reluctance to employ new, safe, more effective, or more economic medical means. Conservatism is at times said to char-
acterize the medical profession, particularly where alternative and holistic medicine are concerned, but a significant contribution to conservatism is made by the legal guidance given the profession by the CMPA. Evidenced in the association's acceptance of the writing of 'do not resuscitate' orders only some time after they were shown to be legally proper through academic analysis and to be desirable in the opinion of professional associations, the adherence the CMPA maintains to traditional modes of practice may appear to support physicians' inhibitions against innovation. Historical language in the law that condemned a physician who acted 'ignorantly and unskillfully, contrary to the known role and usage of surgeons' is invoked to deter physicians' departures from orthodox means of care. Completion of research on animal and human subjects, in accordance with rigorous protocols, and professional acceptance of research results as showing the safety, efficacy, and acceptability of the new means may be required before an innovative medical treatment is considered to be defensible in court. Patients claiming that they were not informed of the innovative nature of the care they received are apt to describe themselves as 'guinea pigs.' In contrast, a number of the orthodox means of care maintained through conservatism are scientifically unproven, and would fail the standards of scrutiny applied to prospective innovations.

The 'guinea pig' complaint is perceived to have a powerful impact in suits determined by juries, which are seen to be vulnerable to emotional pleas by plaintiffs' lawyers, and irrational.

Juries are in fact unusual in Canadian medical malpractice cases, but they may be found, and provide part of the context within which physicians contemplate their conduct being assessed ex post facto. The frequency and shock with which popular journalists newly discover that medical practice may be abused through 'experimentation' induces professional caution, as does the belief that courts will more easily be convinced that a patient accepted an orthodox treatment than that innovative means were adequately explained by a physician and freely allowed by a patient. Medical innovation is by definition practice in which there is relatively little experience, so that a physician's performance of

55 See, for example, K. Johnson 'Beyond Tort Reform' 257 J. of Am. Med. Assoc. 827.
57 Negotiations to reach out-of-court settlements are premised on predictions of what courts would do, so that actual court decisions cast a long shadow over private dispute resolution.
innovative care is liable to be condemned as inexperienced care, however reasonable it may have been to propose innovation and however discredited prevailing orthodox practice may have become. If the orthodox means retain some adherents among comparable competent physicians, departure from such means requires special justification and special disclosure to patients.

A separate effect claimed to result from fear of suit is that physicians will conceal their qualification in circumstances when strangers are in peril and in need of medical rescue by a Good Samaritan. Briefs submitted to the Prichard Review did not invoke this effect, but it has appeared in, for instance, the 1973 DHEW secretary's commission report. Cases in which rescuing physicians have been sued for malpractice have not been found, but a number of US jurisdictions have responded to the risk by enacting statutes of immunity for physicians who render emergency assistance to non-patients. Such statutes tend to do little more than declare the common law, which offers protection against liability for negligence, but not gross negligence. Interesting legal issues have arisen under such statutes when immunity has been invoked by physicians acting in hospital emergencies outside their medical specialties, and when acting within their expertise but when not on call and treating patients of colleagues. The statutes are premised, of course, on anticipation of road-side treatment, and their application to hospital bed-side care is often unclear.

Validity of claims of effects

DEFENSIVE MEDICINE

The ambivalence about the meaning and scope of 'defensive medicine' addressed above appears in responses to the questionnaire employed in the empirical professional practice studies undertaken on behalf of the Prichard Review. Responses contain relatively few explicit disclosures by respondents that they have themselves ordered or performed, because of fear of suit, diagnoses or treatment procedures that they considered

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58 Measuring specialists by the standards of other practitioners of the specialty and general practitioners by the standards of other general practitioners; see Wilson v. Swanson, supra note 39.

59 Although physicians are not required to disclose when they are undertaking procedures without supervision for the first time; see Hopp v. Lepp (1980) 112 DLR (3d) 67 (SCC).

60 Supra note 24, 15

non-beneficial. Statements addressing defensive medicine tended to speak of practices of non-specified others: 'There is increased usage of laboratory, ultrasound and x-rays for no medical reason,' for example, or 'Too many physicians are doing cesarean sections and over-aggressive treatment for fear of litigation,' or 'I try not to let the litigation issue affect my practice. I realize that the above issue is leading to a great deal of costly and unnecessary investigations in hospitals.'

In contrast, however, respondents occasionally disclosed reductions in their practices that were designed to preclude high-risk care giving. This is shown in responses such as, 'I reduced my obstetrical case load to 15-20 cases per month as I don't feel one can adequately manage more high risk cases medico-legally than that level,' or 'More frequent referrals / all complicated cases,' or 'The concern re litigation is always present — it has not always been. There are patients I refuse to treat or do surgery on because I believe they are potential legal actions — I refer them to large university centers,' or 'No longer doing emergencies, or major vascular anesthesia,' or '(1) Reduced patient load; (2) gave up hospital work gradually.'

The statistical analyses of the three professional practice surveys tended to confirm that in some areas fear of suit has resulted in practitioners engaging in defensive medicine, although it is preponderantly 'negative defensive medicine' that has its impact in reducing patients' access to services rather than in making inappropriate and directly un-economic use of resources.

Evidence of the latter practice, of 'positive defensive medicine,' is to be found less in individual cases or anecdotes than in interpretation of the aggregated statistics found by the working groups that conducted the three professional practice surveys. The Working Group on Obstetrics and Gynaecology, for instance, observed that:

62 When made, such disclosures were often ambivalent; for example, 'I tend to be more defensive in dealing with patients and find I often order tests (e.g. x-rays, blood work) when they may not necessarily be clinically indicated.' General Practitioners and Family Physicians study, anecdotal comments, question 9-665.

63 Obstetrics and Gynaecology study, anecdotal comments, miscellaneous comment 340.

64 Ibid. 477.

65 Anaesthesia study, anecdotal comments, miscellaneous comment 429.

66 Obstetrics and Gynaecology study, anecdotal comments, question 4-384.

67 Ibid. question 15-243.

68 Ibid. miscellaneous comment 194.

69 Supra note 65, anecdotal comments, question 7-396.

70 General Practitioners and Family Physicians study, anecdotal comments, question 9-115.

71 See text at supra note 31.

72 Chaired by Dr W.J. Hannah, Department of Obstetrics and Gynaecology, University
There is the constant concern, even in the low risk patient, that something untoward will occur during the course of labour affecting fetal wellbeing and unless the fetal condition is being monitored on a continuous basis, fetal compromise may go unrecognized, leading to an unfavourable outcome. ... [T]his pressure is real and it has led ... to a dramatic increase in the use of intrapartum technology and intervention with no real evidence of the value of these procedures.  

The survey of changes during the previous five years in prenatal ultrasound and biochemical tests for, for instance, alpha fetoprotein and quantitative HCG (human chorionic gonadotrophin) disclosed significant recourse to these procedures. The working group commented that:

These data show that there has been a very substantial increase in a number of diagnostic tests used during the antenatal period. This is particularly evident in the use of ultrasound (both early and late), non-stress testing and biophysical profiles ... the increased use of non-stress testing, biophysical profiles, early and late ultrasound has been strongly influenced by litigation concerns ... 30% of respondents acknowledged that a concern with litigation placed them under an obligation to order any of the previously mentioned tests if these were requested by a patient. The working group was astounded at the magnitude of this figure.  

Similarly, regarding delivery, it was found that:

[T]here has been a very substantial increase in the use of electronic fetal monitoring during labour and a correspondingly high increase in the use of caesarean section for suspected (not confirmed) fetal distress. This is particularly noticeable in those who have been in practice longer than 20 years. ... [O]ne-third of the respondents were strongly influenced in their increased use of electronic fetal monitoring and caesarean section for suspected fetal distress by litigation concerns. Slightly less than one-third (28.9%) were similarly strongly influenced in their decision to decrease their use of mid-forceps delivery.  

It appears that in this area of medical practice influenced by fear of suit, defensive medicine wasteful of scarce resources exists, consisting in the purchase of equipment and the time and skill spent employing it and in interpreting the data gained through its use. The concern about litiga-

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73 Submission of Working Group on Obstetrics and Gynaecology, at 9-10
74 Ibid. 54
75 Ibid. 55
76 Ibid. 56
77 Ibid. 59
78 Ibid. 61
tion affects not only wasted resources, however, but patients' choices. The working group recognized and welcomed patients' greater involvement in medical choices in the care they receive, and was troubled by 'a steadily increasing caesarean section rate' that represented an extreme of medical intervention in the process of patients giving birth to children. The working group found, however, that:

[T]here is at least a perception among two thirds of respondents that in the event that a perinatal complication occurs following delivery, they would be less likely to be sued if they had performed a caesarean section. Given the very careful phrasing of the question (assigning equal weighting to vaginal delivery versus caesarean section), it is difficult to come to any other conclusion than that the majority of obstetricians decide in favour of caesarean sections in cases of suspected fetal distress because of litigation concerns.\(^{80}\)

This may prove to be the enduring conclusion reached by the working group. A finding that litigation-driven recourse to fetal monitoring technology illustrates positive defensive medicine must be placed within a time-frame. The working group observed that:

There has been a general acceptance by the profession and the laity alike that a less than ideal neonatal outcome in the low risk patient is almost always the result of some intrapartum event which might have been prevented. It is only very recently that evidence is accumulating to show that this is not the case, and that many of these bad outcomes are related to events that precede labour and are not related to any intrapartum negligence.\(^{81}\)

It will be a matter of future study to assess whether and, if so, how quickly the profession adopts the new realization that prenatal fetal and maternal monitoring are unlikely to reduce the incidence of bad outcomes. Those who suffer such outcomes may retain the belief that inadequate monitoring caused or contributed to them,\(^{82}\) however, and may remain at least as disposed to initiate litigation as they appear at present. If that is so, then future recourse to these procedures will more clearly illustrate positive defensive medicine.

The Working Group on Anesthetic Care\(^{83}\) reached conclusions that are consistent with those of the Working Group on Obstetrics and Gy-
naecology, but which are less emphatic in identifying positive defensive medicine. Indeed, concerning both positive and negative defensive medicine, the report of this working group offered explanations of changes in professional conduct during the previous five years that operated as well as or instead of fears of suit. The report noted, for instance, that:

About thirty percent of the respondents had ordered more laboratory tests, x-rays and other investigations during the past five years ... Again the concern about litigation was frequently chosen as the reason for the increased use of investigations. However the increasing complexity of medicine in recent years was the most frequently chosen response.\(^84\)

Similarly, the working group concluded that:

It would appear that in recent years anesthetists have made major changes in their practices. They were performing less obstetrical and pediatric anesthesia. They made major changes in the type of drugs they were choosing. The vast majority had increased the use of monitoring, increased the ordering of tests and investigations, increased the degree of documentation of their activities and were spending increased amounts of time explaining the risks of anesthesia with their patients ... For most of the changes, concern about litigation was either the first or second most important reason for the change. However, the availability of new drugs and monitors and the desire to keep up to date with the rapidly changing technology in the field were also major reasons why anesthetists have changed their practices in recent years.\(^85\)

Certain of the changes may on more detailed analysis constitute positive defensive medicine. It was observed that as a group anaesthetists did not have much concern about the higher costs of newer drugs and monitors they were using, and that 'the respondents [did not] seem concerned that the newer drugs and monitors have not always been shown to be efficacious in randomized controlled trials.'\(^86\) Employment of costly, unproven means for fear of suit may seem objectively to be positive defensive medicine, but the distinctive feature of such practice is that it is undertaken by practitioners who do not believe that the procedures they order or undertake are beneficial or useful. No evidence was produced in this study to indicate that physicians were being induced or pressured by fear of suit to use resources in ways they actually considered to be useless or wasteful.

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\(^{84}\) Effect of Liability on the Provision of Anesthetic Care: Survey Results, at 7
\(^{85}\) Ibid. 10
\(^{86}\) Ibid. 11
In its annual reports, the Canadian Medical Protective Association frequently points to the proportion of the defensive resources that are consumed through claims against anaesthetists, averaging about half of the total sums spent. It might be supposed that they would cause the specialty to be particularly concerned with the risk of being sued, and to use defensive means of protection. The survey showed an acute consciousness of the potential for litigation, but no real evidence that responses included recourse to medical procedures that were undertaken simply to forestall legal claims. There was evidence of much innovation and employment of costly drugs and equipment, but no suggestion that they were used other than in a conscientious concern with patients' welfare and the promotion of safe, effective practice.

The Working Group on General and Family Practitioners offered ample evidence of negative defensive medicine, particularly concerning such practitioners' reduced rendering of obstetric, hospital emergency, and anaesthetic services, but offered ambivalent evidence of deliberate ordering or performing of tests believed to be non-beneficial. It has been noted in Ontario that the use of laboratory tests in community medical care rose at about 20 per cent a year from 1984 to 1987, but the working group found no direct reason to believe that such resources were being wasted. The working group's report noted that:

[N]early fifty-eight percent (57.4%) of gp/fm [general practitioner/family medicine] physicians stated that they have increased their ordering of lab tests, x-rays and investigations during the past five years with rural physicians (69.2%) significantly more likely to indicate that they have increased than urban physicians (54.7%) ... Easier access to facilities is mentioned as a reason by one-third of those who increased, particularly those from Quebec. However, less than 15% of these physicians listed it as a major reason for change. Concern regarding litigation was cited as the first or second most important reason for this change by 62.3% of these physicians with relatively little regional variation ... Physicians in practice more than 20 years reported less concern regarding litigation and were less influenced by patient demand than younger colleagues while they cited the increasing complexity of medicine as a major reason for change more often than physicians in practice 20 years or less.

Patient demand appears to explain part at least of physicians' increased use of tests. The working group gave the statistics that:

87 Chaired by Dr W. Rosser, Department of Family Practice, McMaster University
88 Ontario Health Insurance Plan, Laboratory Utilization Statistics 1984-1987
89 The Impact of Medical/Legal Liability on Patterns of General and Family Practice in Canada, at 39
Concern regarding litigation was given as the first or second most important reason for increasing discussion time by 74.5% of those who spent more time discussing risks and benefits with patients. In Ontario, 84.4% of respondents considered this as the main reason.

But they added that:

Patient demand was also seen as a major cause of the increase of test ordering.90

If tests ordered under this pressure are considered useless or wasteful by the physicians who order them, they would constitute positive defensive medicine. Little direct evidence appeared, however, in anecdote and commentary, that indicates that the tests are so regarded. Respondents strongly embraced an attitude that condemned the practice of others, but they made few explicit admissions of having ordered such tests. The working group expressed the attitude of practitioners in observing that:

Physicians often decried the large increases in laboratory tests, x-rays and other investigations that have occurred and saw them as unnecessary or excessive. They noted that they were caught in the middle. They felt that they could not afford to leave a stone unturned even while recognizing that their own clinical judgment was likely a superior source of information. They noted that these practices in the long run would have an adverse effect on health care delivery as costs of health care increase much more rapidly than the system can afford. Although acknowledging their contribution to this problem, without changes in the medical/legal climate and better patient education physicians could not see how tests for tests' sake can be avoided.91

Practitioners' dislike of patient-demanded tests is understandable but the physicians' confidence in 'their own clinical judgment' is less evident where involvement of other physicians in patient management is concerned. The working group commented that:

An area of practice not formally probed but mentioned by a sizeable number of those who wrote in other changes is an increase in referrals and consultations. Physicians also appear to be consulting with their colleagues earlier and more and/or referring patients on to specialists of secondary/tertiary care settings more readily in an effort to lower their perceived medical/legal risk.92

Like ordering tests, consultations with colleagues may be interpreted as

90 Ibid. 44
91 Ibid. 57
92 Ibid. 55
either careful medical practice that protects patients and enhances their management, or as wasteful risk-spreading practice directed to physicians' self-defence. Condemnation of 'tests for tests' sake' can be applied to referrals and consultations simply for their own sake or for the sake of forestalling litigation. The working group’s findings identify the perpetuation of the belief that positive defensive medicine is practised, but offer little clear evidence of its existence and do not differentiate between physicians' self-serving reduction of the risks of being sued or found liable, and their patient-serving reduction of the risks of diagnoses or therapies being inadequately determined.

REduced Access to Services

Through both statistical analysis and anecdotal evidence given by physicians, the three working groups demonstrated that fear of litigation and of legal liability are contributing to changing styles of medical practice. Practitioners may decline to accept certain persons as patients, or to undertake types of procedures. Some have given up areas of practice in which they do not feel that they have, or that they can maintain, proficiency. The effect may be to reduce patients' access to medical services delivered by experienced practitioners when and where patients seek them. Patients do not necessarily forfeit access to a satisfactory standard of care, but they gain care at a cost of suffering inconvenience and perhaps delay.

The Working Group on Obstetrics and Gynaecology found that:

36% of respondents have indicated that they have stopped or reduced their obstetrics practice in the past 5 years. By itself, this represents a substantial number of practising obstetricians in this country. Of even greater significance, however, is that 23% stopped or reduced obstetric practice after less than 10 years of practice and almost 38% did so after 11-20 years of practice. Not surprisingly, the largest percentage of those who stopped or reduced practice have been in practice for greater than 20 years.93

Fear of legal liability was not the major reason, however, for practitioners' termination or reduction of obstetrical care. Desire for a lifestyle change was cited by almost 48 per cent of physicians as the most important reason for their change in practice and 21 per cent gave this as their second most important, while 11 per cent cited concerns about legal liability as their most important reason and 15 per cent gave this reason as their second most important.94

93 Submission of Working Group on Obstetrics and Gynaecology, at 48
94 Ibid. 51
Regarding medical procedures, the working group found that, in the previous five years, as a result of practitioners' concern about litigation:

In relation to gynaecology, close to 20% have avoided certain gynaecologic procedures, certain medications and have promoted certain office procedures, while a smaller percentage (12.1%) have avoided certain office procedures ... It is of interest that those respondents who specified the gynaecologic operations they are avoiding identified vaginal surgery and difficult abdominal surgery more often than any other types of operations. The insertion of IUDs was the single most frequently mentioned office procedure that is being avoided.95

The working group concluded that:

The use of certain gynaecologic operative procedures and medications has been reduced for 1/5 of the survey respondents because of litigation concerns. This has the effect of limiting access of Canadian women, to some degree, to a choice of acceptable surgical procedures which would otherwise be available to them. Waiting lists will be extended and in some communities certain procedures which are generally part of a gynaecologist's practice profile will simply not be available.

Again, the fact that concerns regarding possible litigation have promoted these decisions rather than medical considerations is disturbing.96

It was concluded that concerns over legal liability, coupled to the current shortfall in practising obstetricians and gynaecologists97 available to meet the demand for their services, place Canadian women in a situation of growing crisis.98

The working group on anaesthetic care also showed that practitioners had made selected withdrawals from treating high risk patients, but did not express the degree of alarm found in the survey of obstetricians and gynaecologists. Regarding physicians who acted as anaesthetists, it was found that:

Most physicians did not change or increase the amount of their practice devoted to anesthesia and to a lesser degree local anesthesia or spinal anesthesia. Physician respondents were more likely to decrease or exclude the practice of obstetrical anesthesia or the administration of anesthetics to children under two years of age ... The most frequently chosen reason was liability concerns.99

95 Ibid. 65
96 Ibid. 89
97 Ibid. 90
98 Ibid.
99 Effect of Liability on the Provision of Anaesthetic Care: survey results, at 4–5
Taking into account both specialists in anaesthesiology and general practitioners who undertook anaesthesia, and both reductions of particular services and additions of such care as increased discussions with patients and more careful charting of findings, the working group concluded that:

In summary, liability issues have had a profound effect on the practice of anesthesia in the past five years. Liability concerns were rated as the first or second most important reason for making major changes in anesthetic practice, but the perceived hassles of liability were more disconcerting than the increased costs of malpractice insurance. The number of anesthetists personally affected by liability was much smaller than the degree of concern.\textsuperscript{100}

The Working Group on General and Family Practice noted a decline in practitioners’ rendering of obstetrical care, particularly in performing deliveries. It was noted that:

Nationally, almost one third (32.2\%) of physicians reported decreases/exclusion of one or more aspects of obstetrical care from their practices. Significant regional variation was seen with physicians in the West ... least likely to make such changes (26.1\%) while physicians in Ontario were most likely to report decrease/exclusion of obstetrical care provided (39.4\%).\textsuperscript{101}

It was further noted that urban physicians, except in the Eastern provinces, are less likely than rural practitioners to perform deliveries, but that the most dramatic decrease in general and family physicians who consider performing deliveries a part of their practice was in rural Ontario, where over 45 per cent indicated that they no longer perform this service when they did so five years earlier, a decrease from over 85 per cent to under 40 per cent of practitioners undertaking such practice.

It does not follow, however, that the decrease in practice was due primarily to fear of litigation. Physicians who had limited their obstetrical practice during the previous five years were asked to indicate their reasons. The working group found that:

\textsuperscript{100} Ibid. 12
\textsuperscript{101} The Impact of Medical/Legal Liability on Patterns of General and Family Practice in Canada, at 12
enough cases as a reason for decrease/exclusion of obstetrics than those in other regions. Lack of back-up coverage appeared to be an issue in rural areas outside of Quebec. Pressure from family and growth in other areas of practice were reasons more often cited by physicians in practice 10 years or less.  

A reduction in emergency room practice was noted, to the effect that:

[O]ver 30% of gp/fm physicians reported working full time in an ER [emergency room] five years ago, while today only 19.2% report that they do. There is significant variation among regions in the pattern seen ... About sixty percent (61.2%) of gp/fm physicians reported that they worked part-time in the ER five years ago while 42.2% report doing to today.  

It is of interest that practitioners who reduced or eliminated emergency care from their practices gave a desired change in lifestyle as their strongest reason (59.6 per cent of responses), and that ‘concern regarding litigation ranks sixth [of eight options] among the reasons checked,’ being mentioned in 21.5 per cent of responses.  

In contrast to obstetrical and emergency care, general practitioners’ services in the administration of anaesthesia seem to have changed in the past five years only slightly. The working group found that:

Little change is seen in the percentage of physicians administering local anesthesia five years ago (68.5%) and today (67.0%) as only 1.5% have excluded this area from their practices.  

An additional 6 per cent of respondents had reduced the amount of work that they performed in this area.

While the practical impact of fear of suit may appear to be relatively mild on general and family practitioners so far as their reduction and exclusion of types of practice are concerned, their perceptions of liability may be oppressive in more general ways, particularly among older practitioners. The working group noted that:

A sizeable proportion of physicians in practice more than 20 years (24.3%) indicate that they are likely to leave practice within the next five years if the medical/legal climate continues while only 4.0% of those in practice 11–20 years make this claim, and 10% of those in practice ten years or less endorse this statement.
This sentiment may reflect the significance that practitioners attach to pursuit of an appealing lifestyle, and changes of practice that are designed primarily to enhance lifestyle. Liability to be sued may reduce practitioners' enjoyment of their practice, and dispose those less willing and confident to adopt new styles of practice and of relating to patients to leave medical practice prematurely.

THE EMOTIONAL COSTS OF MALPRACTICE LITIGATION
The working groups received many more responses to the fear of litigation than to the personal experience of it. Indeed, the impact that litigation appeared to have on most practitioners who commented was through receipt not of a malpractice writ but of the annual bill for the CMPA premium. To some, this appeared tantamount to paying a damage award to an unknown but unjustified plaintiff, although they were spared the self-doubt seen to be associated with actions by actual plaintiffs. Observations expressed concerning decreased satisfaction with professional practice and changes in practice made in pursuit of more congenial lifestyles may have been indirect responses to the anticipated emotional burden of being drawn into the defence of a legal suit.

A small number of respondents mentioned involvement in litigation, mainly as expert witnesses or peripheral parties against whom the claims were dismissed or seemed unlikely to succeed. One respondent was so moved as to observe:

I think there is much more awareness among practitioners about legal problems, but very little among students and resident staff ... [T]he emotional impact of a writ is devastating. 107

This may be contrasted with the more representative observations that speculated about the impact of litigation without reference to direct experience, such as that:

The major problem with litigation is the length of time it is dragged out. By simply being named in a suit, your life can be severely disrupted for 3 to 6 years. 108

The long and drawn-out period of legal action must be devastating for defender and plaintiff concerned. 109

107 Obstetrics and Gynaecology study, miscellaneous comment 292
108 Anaesthesia study, miscellaneous comment 132
109 General Practitioners and Family Physicians study, miscellaneous comment 160
'The only response disclosing personal involvement in a sizeable legal action adverted indirectly to its emotional costs, and commented on the interaction of time and financial costs. The respondent wrote:

Having been involved in a recent major litigation, I would like to see some support other than legal for the physicians. It is easier to do something grossly wrong and pay the patient than to spend 9 to 10 years in a case in the papers, etc. and be innocent. Our method of legal settlement is so slow that the standard of practice often changes in anticipation of a settlement e.g. recent immunization case.\textsuperscript{110}

Beyond this, no response adverted to any emotional injury that had been suffered due to malpractice litigation. A number of responses showed anger towards lawyers, the legal process, and complainants of trivial incidents.

ASSOCIATED EFFECTS OF LIABILITY
It has been seen that, in addition to inducing defensive medical practice, reducing patients' access to services, and imposing emotional costs on practitioners, fear of suit and of legal liability is claimed to have other harmful effects. These include causing irrational use of resources, and discouraging improved innovative methods of practice.

The former effect was not testable by the instrument employed in the three empirical studies commissioned for the Prichard Review, since this produced aggregated data of physicians' practices and responses but offered no means to compare how individual practitioners treated comparable cases. Evidence was produced that practitioners interacted more intensely with patients and had fuller or at least longer discussions with them.\textsuperscript{111} These may have exposed and sensitized practitioners to patients' goals and preferences in treatment, and led to comparable conditions being treated differently in ways that reflected patients' different preferences. Where treatment is governed not by the medical condition of the patient per se but by the type of person the patient is, and is sensitive to the patient's 'priorities and aspirations,'\textsuperscript{112} it may be

\textsuperscript{110} Ibid. miscellaneous comment 692. The case referred to may be the unsuccessful case of \textit{Rothwell v. Raes} (1988) 55 DLR (4th) 193 (Ont. HC) (1990) 76 DLR (4th) 280 (Ont. CA), which was initiated in 1980 and decided on trial in mid-November 1988. The trial judge estimated the costs of all of the related proceedings to conclusion of the trial to exceed one million dollars.

\textsuperscript{111} See further the text below on Demonstrated Effects of Potential Legal Liability

\textsuperscript{112} See the significance Chief Justice Dickson gave to patients' priorities and aspirations in \textit{Morgentaler v. The Queen} (1988) 44 DLR (4th) 385 (SCC) at 402 and following, where the criminal abortion law was held to violate patients' rights to security of the person,
expected that like conditions in different patients will be treated differently, even by the same physician. From an assessment of a single practitioner’s management of like medical cases, different treatments may appear irrational, but from an assessment of patients, those with like preferences may be found to have been treated alike. The criticism that a patient’s pressure and liability to sue may induce a practitioner to behave irrationally presumes that treatment is chosen by the practitioner. Once it is recognized that the practitioner presents treatment including diagnostic options that accommodate the patient’s goals, and that the patient exercises informed choice of diagnosis and treatment, the charge that fear of suit induces professional irrationality loses its force.115

The charge of using resources irrationally retains its impact only when it appears that expenditures of resources on the diagnosis and treatment of like patients differ significantly. When expenditures are determined or controlled by reference to an individual patient’s membership of a diagnosis-related group, as is becoming a growing practice in the private health insurance industry in the United States,114 disproportionate expenditures can be excluded. It is a matter of speculation whether comparable controls will arise through health resource rationing that may be introduced to Canadian provincial health insurance plans in the future. If they do arise, they may have to be accompanied by legislation that limits a patient’s legal entitlements to services that can be funded from the diagnostically determined budget allowed by the health insurance plan.

The claim that medical innovation is deterred by fear that litigation will be pressed, or will succeed at trial, if a practitioner departs from traditional management in order to engage in new medical care, is not sustained by the evidence of the empirical studies. On the contrary, evidence is offered that fear of litigation may provide an incentive to employ new means or equipment. At an anecdotal level, one respondent to the survey of anaesthetic care replied that ‘In a large community hospital department I am able to use the litigation threat both to obtain better equipment for the department and to implement safer practice within the department.’115

protected by section 7 of the Canadian Charter of Rights and Freedoms.


114 For a brief, helpful overview of issues raised in the United States by prospective payment systems, see the components of ‘Cost Containment, DRGs [Diagnosis-Related Groups], and the Ethics of Health Care’ 19(1) Hastings Center Report (January/February 1989) 5

115 Supra note 99, 12
Although the three empirical study interpretations did not link beneficial innovation to fear of legal liability in this direct way, they indicated that the risk of suit had not deterred introduction of new drugs, equipment, or other means of care. The survey of anaesthetic care disclosed that 40 per cent of practitioners had made at least one change in their practice during the previous five years, and explained that:

Concerns about litigation again were frequently cited as the reason for changes in the scope of practice, but the most important reason seemed to be keeping up with the rapidly changing technology in the field of anesthesia ... 93.8% of respondents indicated that they have increased the monitoring of patients during the past five years ... However by far the most important reason was increased availability of monitoring instrumentation.

Similarly, practitioners showed that newer drugs were often considered better than traditional drugs, for instance newer muscle relaxants were considered to have fewer or less severe side effects, and that their introduction to practice had not been deterred. These means were adopted, indeed, even though ‘the newer drugs and monitors have not always been shown to be efficacious in randomized controlled trials.’

General and family physicians reported that almost 24 per cent of respondents had excluded or decreased their obstetrics practice in the previous five years because of rapidly changing technology in the field, and almost as many had ended or reduced their practice in emergency rooms for the same reason. An alternative to declining a case in which newer but unfamiliar techniques of care are available is to refer a patient to another physician, for example a specialist. This may have contributed to the finding that ‘physicians also appear to be consulting with their colleagues earlier and more and/or referring patients on to specialists of secondary/tertiary care settings more readily.’

The survey on obstetrics and gynaecology observed that the introduction of new technologies has placed practitioners in an ambivalent position because, through fear of malpractice liability, they are disposed to use them even for low-risk patients; but patients want less intervention and less technology in childbirth, with which preference the profession
is sympathetic. The specialty confirms that fear of suit has not obstructed the technological or innovative imperative that available technology and available innovation be employed. On the contrary, in some cases there is evidence that prospective legal liability causes use of unregulated technology, such as electronic fetal monitoring (EFM). It was noted that:

The interpretation of EFM tracings is not straightforward and even authorities do not agree on the correct interpretation of a given tracing or the appropriate action that should be taken. In addition, there are no guidelines to define minimal standards of interpretation of fetal heart rate pattern.

Nevertheless, the standard of care today requires EFM for fetal surveillance in all high risk patients. Although the value of EFM in low risk patients is debatable, given the current climate, the decision to forego EFM requires documentation of the reasons and a discussion with the patient (informed consent). Consistently with the professional expectation that technologies would be used, only low percentages of obstetricians/gynaecologists gave rapidly changing technology as a reason for stopping or reducing the practice of obstetrics.

Accordingly, the empirical studies do not support the claim that fear of malpractice liability deters medical innovation, and tend if anything to disprove such a claim.

Demoted effects of potential legal liability

INTRODUCTION

Underlying much of the above description of the indicated effects of physicians' fear of suit is ambivalence about the implications of 'defensive medicine' and reduced access to services. If professional defence consists in wasting scarce resources in useless and perhaps harmful testing, and access to skilled medical services is impaired because their availability is reduced, these consequences of fear of liability are clearly bad. If defence consists in observing legally determined standards of safe service delivery, however, and services to which access is reduced are less safe, less proficient, or less skilled in modern techniques than others that remain, those consequences are not bad and may indeed be good. Accordingly, in the same way that the reports of the three empirical sur-

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121 Supra note 93. 9
122 Ibid. 23-4
123 About 5 per cent of practitioners mentioned this reason, and it was the most important reason for only about 1 per cent. Ibid. 50, 51.
veys were reviewed for indications of the claimed disadvantages of fear of suit, they may be reviewed for evidence that physicians' perceptions of their liability to be found to have fallen short of legal standards have resulted in beneficial effects. An initial effect that should be considered, however, is the effect on physicians' attitudes to the law of their potential to be sued and found liable.

PHYSICIANS AND THE LAW
The fact that law induces consequences in medical practice has caused physicians to complain of lawyers' intrusions into medical care and of the 'crushing embrace of medicine by law.' Responses to the empirical surveys included such observations as:

I feel the legal system may be the major cause and problem in increased medical-legal actions.  

I rather resent the way the legal profession is making money off other professionals.  

My biggest concern is that medical suits are being judged by lawyers. A lawyer cannot possibly comprehend a complex medical situation and tries to make the situation 'cut and dried.' This is not possible. Many are dishonest by nature and use patients and physicians to pad their wallets.

Too many lawyers are very anxious to get the medical people at any cost.

While not necessarily representative, these views reflect on the extent to which physicians understand the nature and operation of law and the orientation of the legal profession. Many appear to believe that they understand the legal issues involved in professional liability. In the General and Family Practice survey, almost 42 per cent of respondents were satisfied that they did, although almost 36 per cent disagreed. Among obstetrician/gynaecologist respondents, about 45 per cent were satisfied.

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125 Anaesthesia survey, miscellaneous comment 155
126 Ibid. 354
127 Obstetrics and Gynaecology survey, miscellaneous comment 384. Some might, of course, protest the assertion that lawyers are 'dishonest by nature,' and claim that dishonesty is a product of training.
128 General Practitioners and Family Physicians survey, miscellaneous comment 037
129 Supra note 101, 51
satisfied and 35 per cent disagreed\(^\text{130}\) that most physicians understand the legal issues in malpractice liability. A number of individual comments suggest, however, that physicians might be more comfortable with their legal situation if they had a more adequate sense of the role of law in society and of the focus of the legal practitioner whose client is a patient or former patient who presents a complaint about medical care that has been rendered.

It may be understandable that physicians suppose that decisions about medical care are themselves medical decisions, which only physicians can make and understand. They may distrust patients’ capacities to make such decisions and even to comprehend the information about their care that the law requires that they be given under legal doctrine on informed consent. A respondent to a survey observed that:

The concept of ‘informed consent’ is absurd: few patients understand the risks of surgery, and if they were told of every complication possible then many would refuse surgery which could make them well and even save their lives.\(^\text{131}\)

In law it is recognized that a medical care decision is not in itself a medical decision, but a personal decision to be made by the patient that centres on the patient’s own goals, preferences, and ‘priorities and aspirations.’\(^\text{132}\) The decision must be adequately (not necessarily ‘fully’) informed,\(^\text{133}\) and usually made after discussion with a physician who is aware not only of medical options but also of the patient’s goals in health care and in life in more general regards that medical options may serve. The role of the physician is to determine and distill relevant medical information that may serve the patient’s goals, and to communicate this in a way that presents the choices the patient has.\(^\text{134}\) Legal doctrine on informed consent serves a patient’s interests not simply in health care, but in autonomy.

Physicians are trained to identify patients’ health interests and dedicate themselves to serve those interests. In contrast, lawyers take their clients’ instructions, and advise clients about their choices and about the

\(^{130}\text{Supra note 93, 83}\)

\(^{131}\text{Supra note 127, 154}\)

\(^{132}\text{Supra note 112}\)

\(^{133}\text{See B.M. Dickens, supra note 113.}\)

\(^{134}\text{The law requires the physician to offer information pitched at the reasonable or prudent person in the patient’s circumstances, otherwise described as the ‘objective patient.’ Information must be adjusted to what more is known about the individual, but a patient has a responsibility to disclose departures from what is reasonably presumable. See Reibl v. Hughes (1980) 114 DLR (3d) 1 (SCC) and B.M. Dickens, supra note 113.}\)
implications and foreseeable outcomes of their choices, but do not pre-
sume to direct clients' choices. They may become decision-makers only
when given the clearest instructions and authorization. In the spirit
of serving and defending individuals' autonomy, lawyers will assert
patients' rights to have made their own perhaps poor medical choices
provided that they were adequately informed. Physicians who have con-
scientiously served patients' interests in health and in preservation of
their very lives may be distressed that lawyers argue patients' rights to
make disadvantageous medical choices and to forgo benefits that medici
ne may offer them when properly applied. Physicians may be frus-
trated that legal obligations to respect patients' autonomy may prevent
them from rendering the beneficial services for which they are trained,
and that lawyers appear dedicated to support patients in refusing,
structuring, and setting conditions on physicians' practice of their judg-
ment and skills.

Physicians resent not only their vulnerability to be found liable when
sued, but also to be sued when not liable. One respondent, for instance,
observed with clear regret but sound perception that:

One of the most frustrating aspects of medical practice in a high-risk field is that
you feel powerless to prevent litigation - no matter how careful I am, I have the
feeling I cannot prevent being sued.

Another protested that:

Obviously the legal system and lawyers in particular make a living (in part)
through medical litigation. Hungry lawyers may launch groundless suits. This
needs to be stopped!! Tormenting doctors for profit is immoral. My first sugges-
tion would be to cut supply of lawyers - those in practice could then concentrate
on justified civil suits.

The misunderstandings that justified suits can be distinguished from the
unjustified before final judgment is given, that lawyers should judge
their clients' choices, and that lawyers initiate suits or can stop clients
from initiating them, show how much the legal profession needs to
educate physicians and, no doubt, the wider community about the law,

135 See B.M. Dickens 'Patients' Interests and Clients' Wishes: Physicians and Lawyers in
136 See Malette v. Shulman (1990) 67 DLR (4th) 321 (Ont. CA), where a Jehovah's Witness
plaintiff was awarded $20,000 in damages after undergoing a medical procedure that
the judge found might have saved her life, when she had indicated that she did not
want that procedure.
137 Supra note 127, 466
138 Ibid. 023
individuals' legal rights to instruct lawyers to take action, and court processes.\textsuperscript{139}

Beyond explaining individuals' legal rights of recourse to the courts, even in claims that prove to be unjustified, the legal profession might also explain and demonstrate the courts' function in setting standards of conduct. The courts' knowledge of the practice of medicine, for instance, is usually supplied by expert medical witnesses presented by parties to litigation, but much of the courts' role is discharged through perceptions not of physicians but of patients; that is, through their knowledge of the nature of society and its members, and of their rights, legitimate expectations, and obligations. Courts set standards by interpreting the terms that are expressed and, particularly, by articulating the terms that are implied in contracts for the rendering of medical care,\textsuperscript{140} and, perhaps more significantly, by determining the existence and standards of duties of care in tort law. The courts' powers to explain the law with regard to fiduciary duties, for instance, may also show physicians' responsibilities to persons other than their patients.

Although the courts retain a residual right to set standards in accordance with social expectations,\textsuperscript{141} they usually hold general medical practitioners to the standards of proficiency proven to be maintained by their peers, and specialists similarly to the standards found within their specialty.\textsuperscript{142} With regard to such matters as physicians' obligations to present patients with choices of care that meet their needs, however, meaning the duty to obtain 'informed consent' to medical management,\textsuperscript{143} courts in Canada\textsuperscript{144} focus not on the practice among physicians but on what should be understood about patients.\textsuperscript{145}

Regarding such medical matters as maintenance of written records and monitoring of treatment, courts are strongly guided by expert evi-

\textsuperscript{139} The individual's right of recourse to the courts may be excluded by legislation that disallows particular types of claims, such as 'wrongful life' claims that have been prohibited by statute in a few US jurisdictions, subject to constitutional challenge. In Canada, workers' compensation schemes commonly channel claims to boards and preclude immediate access to the regular courts.

\textsuperscript{140} A contract exists between a physician and a patient where the physician charges on a fee-for-service basis, even though a third party such as a provincial health insurance plan both pays and establishes the service fee.

\textsuperscript{141} See A.M. Linden, supra note 61, 143, n321

\textsuperscript{142} Wilson v. Swanson (1956) 5 DLR (2d) 113 (SCC)

\textsuperscript{143} The expression 'informed choice' is to be preferred to 'informed consent'; see B.M. Dickens, supra note 113.


\textsuperscript{145} See Hopp v. Lepp, supra note 59 and Reibl v. Hughes, supra note 134.
idence of standards of competent professional practice to the extent that a defendant proven to have fallen short of such standards may be in an indefensible position. Conformity to professional standards will not necessarily be exonerating, however, since the courts are guided but not governed by such standards, and may find that reasonable public expectations are of higher standards than the profession commits itself to uphold. The medical profession is self-regulating in that it sets ethical standards of professional conduct with which courts are slow to interfere, but the profession does not determine patients' legal entitlements. The courts discharge this function, and thereby set legally required standards of professional conduct. Legal process, particularly through the courts, is a social means of standard-setting for a wide range of activities of which medical practice is a relatively minor part.

How effective and efficient the courts are in setting and maintaining standards is a matter of judgment. Judicially determined expectations of professional behaviour must be communicated to members of the medical profession, through such means, for instance, as medical school education, post-graduate and continuing medical education courses, general professional and specialized journals, and guidance from insurers and medical defence associations, particularly the CMPA. It might be hoped that instruction in legal expectations will be taken in a spirit of inspiration and enlightenment to serve patients' legal entitlements, but fear of legal liability will operate as effectively and perhaps more realistically to induce conformity to standards. Standards set by courts that are considered untenable may be politically challenged and changed by legislation.147

DEFENSIVE MEDICINE AND ACCESS TO SERVICES

It has been seen above that so-called defensive medicine is ambivalent in its meaning. Physicians used the expression pejoratively regarding others' practices and in speculation about rising health service costs, but respondents to the empirical surveys who raised self-doubts about their motivations, for instance, in ordering tests and seeking consultations with specialists invariably left open the possibility that such practices might help patients. The chances of the extra care identifying important but previously undetected information was considered rather remote. Action

146 See Re D and the Council of the College of Physicians and Surgeons of British Columbia (1970) 11 DLR (3d) 576 (BCSC) and A.M. Linden, supra note 141.
147 See the legislative reversal of the Washington State Supreme Court's decision in Hel- ting v. Carey (1974) 519 P. 2d 981, in which the Court set a higher standard of care than a health profession had customarily observed: B.M. Dickens, supra note 135.
taken out of an abundance of caution still contributed to caution, however, and even though the probable marginal benefit of the additional step was felt likely to make it cost-inefficient, no physicians confessed that they had deliberately ordered tests that they believed were without any value, or disproportionately hazardous, in order to appease a patient or provide a defence available in the event of litigation.

Tests believed to be of some but not much value to patients were an expense to provincial health budgets, but patients apparently accepted that the risks of such tests were warranted by the potential to be aided and the low risk of the tests causing harm. Detriment to the economy of provincially funded health care was not a reason for patients to decide to forgo adequately safe tests that might help them. Health professionals aware of costs, and aware that the marginal tests that incurred them meant that preferable alternative health services would have to be foregone, were critical of the tests being ordered. The link between defensive medicine and the inefficient use of resources was made by recognizing that defensive medicine reduced the population's access to other health care services. Little empirical evidence was found, however, to establish that fear of suit caused responding physicians to order tests, seek consultations, or engage in like practices that they themselves considered to be of no value to patients or disproportionately hazardous.

In contrast, considerable evidence was found that physicians so changed their patterns of practice under fear of suit that their services became unavailable to patients. While patients' convenient access to services was thereby reduced, there was little evidence that the standard of services that remained accessible to patients was reduced, and evidence indeed that average standards were actually enhanced. Withdrawn and withheld services tended to be those of practitioners who believed that their proficiency was apt to be below standard because of, for instance, the relative infrequency of their practice in that service. High-risk patients and high-risk procedures tended to be left to more skilled or experienced practitioners, and procedures whose safety depended on back-up services or refined equipment tended to be left to facilities where such services or equipment were available.

The survey of practice in obstetrics and gynaecology disclosed 'a situation of growing crisis' concerning a shortfall in practitioners. The alarm expressed by leading members of the specialty warrants serious attention, and if legal liability or fear of suit significantly contributes to

148 See supra note 98.
a shortfall of practitioners in such an important specialty there is cause for profound concern. Multi-million-dollar damage awards to brain-damaged infants have become familiar in the United States, and Canadian experience includes such cases. It is clear to see how the prospects of such liability, and of paying increased CMPA premiums for a limited practice in the field, might deter practitioners. Evidence from the empirical surveys indicate that it is primarily the field of obstetrics from which specialists and general and family practitioners are withdrawing, and where presumably any shortfall would have its effect.

The supply of medical practitioners tends to be calculated in the population on a per capita basis. On this measure, the availability of practitioners of obstetrics can be shown to have declined. Figures are not available, however, to relate numbers of practitioners to movements in the birth rate. With an aging population and a declining birth rate in Canada, the demand for practitioners' services might be expected to decline. For more than the last decade the Canadian fertility rate has been below replacement level.149 The number of children per woman in Canada, which was 3.88 in 1956–1961, had fallen to 1.66 in 1981–1986.150 A fall in the demand for obstetricians' services might explain a fall in their numbers and in availability of their services in the population per capita.

Obstetricians’ concerns regarding declining availability of services and physician's general concerns that the community may experience a decline in access to health services, coupled to practitioners' apparent comfort that in their own clinical practices they have not wasted resources, reflect a contradiction of which the profession is increasingly aware. Physicians' claims to serve their separate patients, and to be their advocates to government in demands for health care services that are prudent for patients to have, are in conflict with physicians' expectations that the community's health care resources be wisely husbanded and deployed economically for collective advantage. The contradiction is a macrocosm of that which the profession faces, and fears, at the institutional level when physicians are responsible for allocation of globally fixed budgets among competing patient demands.

It has been observed that:

Until recently ... physicians could act unreservedly as advocates for their patients. Several important factors have changed this, most generated by the need to

149 R. Lachapelle ‘Changes in Fertility Among Canada’s Linguistic Groups’ Canadian Social Trends Statistics Canada (Autumn 1988) 2
150 Ibid. 7
control rising costs. In Canada ... physicians are being pressed to consider society's needs in deciding the amount of medical care needed by each patient; such considerations seem rational in the abstract but create an apparently insoluble problem in the particular case.\[151\]

Observations such as that

[1]he physician in the 1980s faces a conflict between acting as his patient's unfettered advocate and behaving responsibly to society in general by trying to restrain the costs of health care\[152\]

echo increasingly frequent observations expressed in the United States\[153\] and Britain\[154\] that are generating an active literature written by Canadian physicians.\[155\] It addresses the physicians' tradition of uncompromising commitment to the patient as an individual whose needs must be served without regard to cost or consequences, and the extent to which physicians are conscripted by government and society to act as gatekeepers to expensive treatments that are unavailable to serve all who want access to them.

That physicians blame defensive medicine induced by fear of suit and legal liability for contributing to declining health care resources is understandable. Litigation and liability to suit may indeed lead to the redirection of some health care resources away from rational provision of health services within the community. This is not the sole cause of patients suffering reduced access to services, however, and the role of legal liability in the wider context of provincial and territorial provision of health care warrants further assessment. Fear of litigation and liability may have a more direct effect in causing some practitioners to decline to offer particular services and thereby reduce patients' convenient access to care. This issue must be assessed, however, in the general context of the demonstrated effects of liability to malpractice litigation on how physicians practice, considering not just the convenience of access to health care but also the quality of physician-patient interactions.

\[152\] Ibid. 23
\[153\] See for example A.S. Reiman 'Cost Control, Doctors' Ethics, and Patient Care' in Issues in Science and Technology (Winter 1985) 193.
PHYSICIAN-PATIENT INTERACTIONS

A much-cited study by Professor Gerald Robertson, conducted shortly after the Supreme Court of Canada presented its highly significant 1980 judgment on informed consent in Reibl v. Hughes, concluded that the case was poorly recognized and understood by physicians. General Counsel to the CMPA wrote after the judgment that "[n]o legal event in the last fifty years has so disturbed the practice of medicine as did the decision of the Supreme Court of Canada in Reibl v. Hughes." The association consequently undertook to educate its members, who represent all but a very few of the practicing physicians in Canada, about the effect of the decision, emphasizing the need for better communications between physicians and patients. The negligence found in Reibl v. Hughes consisted not only in the patient not knowing enough about treatment options but also, and initially, in the physician not possessing enough information about the patient to offer him appropriate treatment options for the realization of his goals in seeking care. Robertson's study indicates that early progress in this educational task may have been slow, but the three empirical studies conducted for the Prichard Review present impressive evidence that the thrust (if not necessarily the name) of the judgment is now known to physicians.

The working group on obstetricians and gynaecologists reported that the CMPA newsletter was the most commonly cited source of information that practitioners had received about professional liability in the previous five years, being identified by about 90 per cent of respondents. The survey of anaesthetists showed that almost 93 per cent were informed by this source, and the figure for general and family practitioners exceeded 88 per cent, ranging from 76.6 per cent in Quebec to 92.2 per cent in the West. In Quebec, articles in professional journals were cited by almost 90 per cent of respondents as a source of information, the average for general and family practitioners in Canada being 74 per cent. Among anaesthetists, professional journal articles were the second most frequently cited source of information to the CMPA newsletter, being cited by 67 per cent of respondents, although the newsletter was the most influential source, being cited as such by over

156 Supra note 13
159 Supra note 73, 43
160 Supra note 84, table 1
161 Supra note 89, 9
162 Ibid.
39 per cent of respondents when only 7.6 per cent found articles the most influential.\textsuperscript{163} More obstetricians/gynaecologists found informal discussion with colleagues informative on professional liability (over 80 per cent) than those who were informed by journal articles (almost 70 per cent).\textsuperscript{164}

Whatever their most frequent or most influential source of information was, physicians appear to have absorbed the message of the law, expressed in \textit{Reibl v. Hughes}, that they must communicate more adequately with their patients. Spending more time in discussion does not ensure, of course, that the time is well spent; increased quantity of interactive time does not guarantee the quality of discourse and critical information exchange. An increase in time spent may, however, be positively related to, and may even be a precondition of, achievement of the required quality of human interaction. Accordingly, increased time spent in the physician-patient interaction may indicate that the value embodied in the judgment in \textit{Reibl v. Hughes} is being respected and perhaps achieved. This may be at some financial cost to physicians where applicable health insurance plans limit consultation time that is funded, for instance, to 20 minutes.

The empirical survey of obstetricians and gynaecologists found that:

Almost 80\% of respondents indicated that they have increased the amount of time they spend with patients discussing risks and benefits of treatments in the past 5 years. Concern regarding litigation, once again, prompted more (86.4\%) positive responses than any other reason.\textsuperscript{165}

Similarly, among anaesthetists an improved quality of physician-patient interaction was found, and attributed to legal liability. The survey of practitioners states that:

The last question in this series asked anesthetists if they were spending more time with patients discussing the risks and benefits of treatment. Sixty-three percent of the respondents answered the affirmative. The reasons for the increase are seen in Table 9. Patient demand and suggestion from CME [Continuing Medical Education programmes] were often cited reasons why the respondents had increased their time with patients. However the most compelling reason was concern about litigation.\textsuperscript{166}

Table 9 shows that increased time spent with patients was explained as

\textsuperscript{163} Supra note 84, table 1
\textsuperscript{164} Supra note 73, 43
\textsuperscript{165} Ibid. 75
\textsuperscript{166} Supra note 84, 7
being due to concern regarding litigation by almost 84 per cent of respondents, a product of continuing medical education by almost 59 per cent, and due to patient demand by almost 52 per cent. However, when asked to give the most important reason, over 53 per cent of respondents said litigation concerns, under 21 per cent said patient demand, and under 12 per cent said continuing education.

The survey of general and family practitioners disclosed consistent results, although at a marginally lower level. This is predictable among practitioners whose general work appears to leave them less likely to be sued than more specialized or high-risk practitioners. It was found that:

Sixty percent (60.6%) of gp/fm physicians nationally indicated that they had increased the amount of time they spent with patients discussing the risks and benefits of treatment ... Concern regarding litigation was given as the first or second most important reason for increasing discussion time by 74.5% of those who spent more time discussing risks and benefits with patients. In Ontario, 84.4% of respondents considered this as the main reason for their change while physicians in other areas cited this reason less frequently.167

Although the questionnaires addressed physician-patient discussion of risks and benefits of treatments, physicians frequently made the point that patients' unrealistic expectations of what medical interventions could achieve fuelled patient dissatisfaction and consequent litigation. It is interesting to speculate whether any of the additional time many physicians appear to have given to discussions with patients was spent in physicians making patients more aware of the limitations and irreducible failure rates of medical procedures. Anecdotal responses to questions often made reference to fuller discussions and greater attention being given to informing patients, as well as to limiting telephone advice or taking care immediately following a telephone conversation to document details of the discussion. Representative anecdotal observations include:

more careful charting, less telephone advice, seeing unresolved problems more frequently until resolution with less regard to patient inconvenience of many office visits;168

more attentive to phone complaints, more time and detail re operative risks, more discussion with family;169

167 Supra note 89, 41–4  
168 Supra note 128, question 9, answer 1013  
169 Supra note 127, question 15, answer 177
must admit I have become more meticulous about my quality of care to my patients in particular with developing good rapport and ensuring they have a good understanding of their medical problems before initiating active management. Litigation does not really affect my practice otherwise; 170

increase in monitoring, more information prior to general or regional anaesthesia; 171

greatly increased documentation, increased emphasis on personality contact component of pre-operative visit and patient advice about the sequence of events that will occur. 172

Some practitioners were resentful of having to direct their minds to what the law, sometimes personified as ‘lawyers’ or ‘expert witnesses,’ expected of them rather than to their patients’ needs. Others accepted modern obligations with a sense less of their utility than of their futility, shown in the observation that:

I request more consults with internists and anesthetists, I order more lab work to cover all bases. I spend a much longer time trying to give patient information, they do not listen as they never have. 173

Whatever their incentive may be, however, it is apparent that many physicians are conforming in fact to the discourse with patients that the Supreme Court of Canada indicated in Reibl v. Hughes is required.

Closely parallel in its effect is the impact that fear of legal liability was demonstrated to have had on physicians' documentation of their dealings with patients. Indeed, physicians' responses to the three empirical surveys mentioned the impact of fear of suit on charting practices more often than on extended discussions with patients. Careful charting was usually explained at best as a duty owed to patients, and more frequently as a practice motivated by its service to the physicians themselves in maintaining their legal defences in good repair. Relatively infrequent was recognition that health professionals communicate among themselves through the individual patient's medical record, and that one practitioner's conscientious documentation affords colleagues necessary information for patient care and protection.

170 Ibid. miscellaneous comment 011
171 Supra note 127, question 7, answer 076
172 Ibid. answer 212
173 Supra note 127, question 15, answer 001
The Working Group on Obstetrics and Gynaecology, which was the most critical of the three working groups concerning the effect of legal liability on patients’ care, recognized that fear of suit had improved charting practice. The working group’s survey of practitioners found that:

80% of respondents indicated that they have increased their documentation on what has been done for or discussed with patients in the past 5 years ... Of all the reasons why documentation has been increased ... concern regarding litigation was mentioned by over 93% of respondents ... [C]oncern regarding litigation is, by far, the single most important reason for increased documentation. Since adequate record-keeping is considered an integral part of good medical care, this phenomenon can be regarded as a positive effect for respondents concerned about litigation.174

Similarly, the working group on general and family practitioners reported that:

Nationally, 71.6% of gp/fm physicians agreed that they had increased documentation of what they had done or discussed with patients during the past five years ... Concern about litigation was considered the first or second most important reason for increasing documentation during the past five years for 87.5% of respondents.175

The survey of anaesthesiologists produced consistent results, but also disclosed that changes in technology affected styles of practice as much as potential legal liability. The working group found that:

Over 75% of the respondents answered ‘yes’ to the question ‘Have you increased documentation of what you have done or discussed on patient records during the past five years?’ The most important reason was overwhelmingly concern regarding litigation.176

When practitioners who had changed the scope of their practice apart from the actual conduct of anaesthesia were asked to give their reasons, almost 54 per cent cited litigation concerns, but almost 59 per cent referred to changing technology. Further, only 22.3 per cent said that litigation concerns were their most important reason for changing their general scope or style of practice, but 39.4 per cent attributed change

174 Supra note 73, 69, 70, 72
175 Supra note 89, 41
176 Supra note 84, 7
most importantly to technological change. A greater disparity was seen when respondents gave reasons for undertaking increased monitoring of patients. Concern regarding litigation was cited by 63 per cent, almost 65 per cent said that they were reacting to recommendations of their specialty medical society, and 98.4 per cent cited increased availability of monitors. Litigation concerns were given as the most important reason for the increase, however, in only 9.5 per cent of the cases, while over 53 per cent explained their expanded monitoring practice by referring to the increased availability of monitors.

This may suggest obedience to a technological imperative, but the link between availability of equipment and legal liability may be close. It has been seen from anecdotal evidence that risk of liability may induce a hospital to make monitoring equipment accessible, notably by purchasing it. Similarly, recommendations by societies of anaesthetists that increased monitoring be undertaken may be primarily inspired by potential improvements in patient management, but this is clearly related to reduction of legal liability. Accordingly, the influence of the law may be greater, though less direct, than these statistics show.

The empirical studies show that the intensity of physician-patient interactions has grown in the past five years, and much suggests that this has been for the better. That is, patients have been better served by fuller discussion, by disclosure of more information about treatment choices and the features of each, including the risks, and, for instance, by more careful and adequate charting of information. Standards of general disclosure and of identification and explanation to patients of treatment options may have been raised in response to legal doctrines the courts have developed, usually in litigation, alleging medical liability. The effect may have resulted, however, not from legal doctrine per se but from patients' liability to sue and thereby to harass practitioners for several years.

**RISK-REDUCING STRATEGIES**

In response to its perception of liability to suit, the medical profession has adopted a number of risk-reducing strategies that are applied at individual, institutional, and professional levels. The strategies are not purely defensive of physicians, but anticipate dangers and aim to reduce patients' liability to suffer injury.

177 Ibid. table 6
178 Ibid. table 7
179 See text at supra note 115.
The principal individual means that physicians employ to this end have been reviewed above. They include, for instance, termination of practice when a physician may fall short of legally required standards of competence, rejection of a procedure that a practitioners considers too prone to lead to complications or injuries, ordering tests that may produce additional information about a patient while not themselves adding materially to risks, and consulting with specialists or referring patients to them. Improved information-sharing with other health professionals involved with a patient, through more careful and comprehensive charting, increased monitoring of care delivered in order to identify any adverse side-effects and ineffectiveness or dysfunctions of treatment, and more intensive and explicit discussions between physician and patient are all initiated in the hope that they will satisfy not only legally determined standards of care but also, and perhaps more significantly, the patient's needs of safe management. Comprehensive charting of discussions, any treatment ordered, and its consequences also facilitates investigation of any incident that may occur during the course of treatment.

Hospitals are investigating incident reports with increasing care in order to reduce repetition of injuries, and are exercising greater vigilance and anticipation of potential causes of harm to patients and others. Risk management and quality assurance committees and programs are increasingly being established and encouraged and the Canadian Council on Hospital Accreditation, which recently renamed itself the Canadian Council on Health Care Facility Accreditation in order to expand its scope, has moved to require all facilities to operate such committees, perhaps at a variety of levels, as a condition of accreditation. As such committees move from a reactive role of investigating incidents retrospectively to a proactive role of implementing strategies designed to forestall incidents harmful to patients, hospital staff at all levels may be, and feel, subjected to increased supervision, and may experience decreased professional autonomy. The implementation of risk management and quality assurance programmes may require special sensitivity where bureaucratic control is in the hands not of health professionals such as physicians but of administrators such as health service executives.

Nevertheless, medical professional support of such programs is strong. In its brief to the Prichard Review, the Canadian Medical Association observed that:

Programs to address quality of care have been in place for many years in Canadian hospitals. Recently these quality assurance programs have been augmented or accompanied by new systems designed to give early warning of potential danger for patients, staff, medical personnel and visitors. Adapted from insurance and industrial safety programs ... risk management's just beginning to
make inroads in Canada ... These programs are in nascent stages in most locations, but the CMA is encouraged by their appearance.\textsuperscript{180}

The CMA urged that development and implementation of risk management and patient safety programs become a requirement of hospital accreditation, and itself has undertaken a number of initiatives to reduce injuries to patients and consequent legal liability of its members. These include collaboration with health institution-based organizations, namely the Canadian Hospital Association, the Canadian Nurses Association and the Canadian Long-Term Care Association, to develop interprofessional education. The CMA is also working to promote the widespread operation of risk-management strategies, noting that:

Among the first wide-scale initiatives arising from the cooperative efforts among the institution-based groups is an attempt to identify how many hospitals and health care institutions operate risk management programs. This kind of data will be important in developing consistent terminology, which is basic to setting down effective guidelines.\textsuperscript{181}

Concerning failures of care due to individuals' errors, the CMA brief observes that:

At present peer review processes are most highly developed in relation to hospital-based medical practice. Most Canadian hospitals have quality-assurance and medical-audit programs that effectively identify physicians who place patients at unacceptable risk of injury.\textsuperscript{182}

It is further noted, however, that not all hospitals have means to deal effectively with sources of risk, and where means exist firm action may not be taken, including reporting individuals to licensing authorities who may institute fitness-to-practice or professional misconduct proceedings. This presents a point at which the law may be dysfunctional, because conscientious hospitals may identify evidence that may become available to plaintiffs acting against them while hospitals that do not monitor their staff and investigate maloccurrences with a view to protecting patients may not produce evidence of failings that will assist such plaintiffs.

The issue of plaintiffs' access to hospital peer review committees' records for furtherance of their claims against hospitals and individual health professionals is pervasive in North America.\textsuperscript{183} Peer review may

\textsuperscript{180} Supra note 35, 44
\textsuperscript{181} Ibid. 46
\textsuperscript{182} Ibid. 49
\textsuperscript{183} See, for example, J.M. Rowland 'Enforcing Hospital Responsibility through Self-Evalu-
lack necessary penetration and courage in identifying substandard practice and errors in administrative control where review committee records are liable to pre-trial discovery, that is disclosure, to plaintiffs. Calls for appropriate legal privilege against plaintiff's access to these records are inspired not just by medical professionals' self-interest, but by the fear that, if scrutiny of inadequate medical practice is not fearless, risks may be perpetrated and patients may be avoidably injured. The fear is expressed that a patient's success in litigation through recourse to evidence from peer review committee records would be achieved at the cost of avoidable injuries other patients would suffer because peer review committees would decline to operate as thoroughly as they could. A related fear is that, although defamation actions might be defeated through the defences of truth and qualified privilege, libel suits could be initiated on the basis of discovery of review committee records that would expose forthright committee members to harassing and oppressive litigation.

The conclusion drawn in several submissions to the Prichard Review was that legal privilege should be enacted through provincial legislation applicable to the law of evidence in civil cases. Legislation appears to be the appropriate vehicle by which to achieve this objective in Canadian jurisdictions, since Canadian courts may well follow the overwhelming majority of US state courts in finding that the common law rules on privilege, embodied in the celebrated principles of Wigmore's, do not afford privilege from discovery to peer review committee records. The brief submitted by the Saskatchewan Medical Association, for instance, noted its concern that the prevailing provincial Evidence Act does not exempt hospital peer review documents from disclosure in civil proceedings, stating that:

This factor is causing increasing concern. Neither the physician under review nor those doing the review are able to be as candid as they would otherwise be for fear that documented statements could later be used in a court to misconstrue the physician's role in any adverse outcome being reviewed by the court.

184 Wigmore on Evidence 3d ed. (1940) vol. 8, c. 81, s. 2285, at 531, namely: (1) The communications must originate in a confidence that they will not be disclosed; (2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties; (3) The relation must be one which in the opinion of the community ought to be sedulously fostered; and (4) The injury that would inure to the relation by the disclosure of the communication must be greater than the benefit thereby gained for the correct disposal of litigation' (emphasis in the original).
185 See J.M. Rowland, supra note 183, 394; compare US federal courts, ibid. 396.
We believe that systematic peer review is an important factor in the promotion of health care standards. Factors which serve to undermine that process are counter to the public interest.\textsuperscript{186}

The CMA brief addressed both privilege from disclosure to private litigants of peer review committee records, and protection for hospital agencies and officers responsible in good faith for referring members of the medical staff to the provincial licensing authority. The brief recommended that provincial protection for the latter be provided, and that the principle of protection from disclosure in legal actions of the proceedings of hospital-based peer review committees or other hospital professional staff committees evaluating and reviewing institutional quality of care be endorsed and that provincial governments be encouraged to adopt legislation enshrining this principle.\textsuperscript{187}

The CMA went further to recommend peer review and audit of office-based medical practice, which it observed is not highly developed in Canada.\textsuperscript{188} The College of Physicians and Surgeons of Ontario has, however, pioneered an office-audit program that has shown potential to detect unsafe practices. Similarly, the Anaesthetic and Operative Deaths Committee of the Alberta Medical Association, reviewing 488 deaths that occurred within ten days of surgery and finding that 28 were 'possibly preventable,' warned that some physicians are practising 'beyond their skills' and should be restricted in their practice by medical staff organizations in hospitals.\textsuperscript{189} This type of monitoring of practice considerably exceeds the purely educational role that medical associations discharge to limit malpractice, but requires that investigative agencies of licensing authorities have powers to audit physicians' hospital-based and also office-based practices by compelling access to patients' records, and perhaps that committees of licensing authorities be able to act without liability to have their records made available at the request of civil plaintiffs.

The self-regulatory functions of provincial licensing authorities cannot confidently be described as providing a means to reduce patients' vulnerability to suffer injuries. Such authorities' potential to conduct enquiries on practitioners' fitness to practice and on allegations of professional

\textsuperscript{186} Saskatchewan Medical Association brief, at 2
\textsuperscript{187} Supra note 35, 50. The Canadian Medical Association/Canadian Bar Association Liaison Committee made a similar recommendation in 1985; see CMA Proceedings of the 118th Annual Meeting including the Transactions of the General Council (1985) 37.
\textsuperscript{188} Ibid.
misconduct has not produced incisive effects on individual physician’s liability to harm patients. The report to the Prichard Review submitted by the British Columbia Medical Association (BCMA) committee on professional liability in medicine discussed a recent spate of cases against a particular practitioner who was investigated by the Patterns of Practice Committee of the BCMA, the Medical Services Plan, and the provincial College of Physicians and Surgeons, yet his pattern of behaviour did not improve. A further review several years later was necessary before his licence to practice was withdrawn. The BCMA committee report observed that:

In general, the present system [of professional self-regulation] revolves around death and complication rounds and medical audits in hospitals, as well as peer review of physicians whose pattern of practice is determined to be aberrant by the BCMA, Medical Services Plan and Pharmacare. The College of Physicians and Surgeons is undoubtedly well placed to conduct a self-policing of professional liability within the province, yet discussion with representatives of the College indicates that the finding of fault for a single act of omission or commission is usually a long way removed from suspension of one’s licence.  

The committee recommended that, despite the prevailing haphazard and shallow system of monitoring, detailed reporting of hospital and clinic activities should be made to a public body composed of representatives of the provincial College of Physicians and Surgeons, the CMPA and the BCMA, with information ‘to be protected under Bill 55,’ which is the provincial Act that ‘excludes from evidence proceedings of committees of a hospital whose purpose is the improvement of medical or hospital care.’

The many claims for legislative enactment of a privilege from discovery of documents submitted to and produced by peer review committees in hospitals and other health care facilities and by provincial licensing authorities and, for instance, medical associations, are based on the belief that such protection from disclosure in litigation would encourage frankness within committees and promote reporting to them and by them of proof, or at least evidence, of a physician’s perceived liability to injure a patient. They make a compelling case provided that their assertions are correct: (1) that prevailing disclosures to and by such committees are harmfully obstructed because disclosure are legally unprotected; (2) that

191 Ibid. Bill 55, section 5 amended the provincial Evidence Act, RSBC 1979 c. 116, s. 57.
192 Ibid.
THE EFFECTS OF LEGAL LIABILITY ON PHYSICIANS' SERVICES 219

protection of disclosure would induce candour that would establish preventive truths about medical risks to patients and prospective patients; and (3) that privilege from discovery would not lead instead, or as well, to institutions' self-serving protection of their own bad faith, negligence and casualness. The plaintiffs' bar could present evidence from the United States showing that these conditions of privilege have not been satisfied in jurisdictions that have been persuaded to enact laws barring discovery of peer review documents and statements by creating an absolute or, usually, a qualified privilege of non-disclosure.

The legislature of California enacted a provision that made all medical peer review committee records and proceedings privileged from disclosure in civil suits.193 Subsequently, the case of Miosky v. Superior Court,194 which involved staff at a Sacramento hospital who failed to report a physician's gross abuse of patients, showed how the legislation did not promote candour but rather masked a hospital's neglect of its duty to monitor the physician's conduct. Similarly, in University of Texas Health Science Center at San Antonio v. Jordan,195 four years of common discussion in a paediatric intensive care unit of a nurse's association with mysterious and unusual deaths of children, which she sometimes had predicted, failed to link her to any of the deaths, until she was convicted of murder through premeditated improper nursing care. Legislated protection of disclosure of suspicion or evidence of irregularity failed to induce colleagues to take incisive action and the hospital to substantiate or to refute allegations of an exceptionally grave character. Legislated privilege—nevertheless would have denied a complainant against the hospital access to records of how the hospital investigated well-known fears of the nurse's involvement in deaths, and cleared her of any responsibility. These instances196 of privilege, protective not of institutions' bold identification of gross abuses but rather of their inability to protect patients against outrages, raise apprehensions about the privilege the Prichard Review was urged by hospital and medical interests to promote.

Legislation in Manitoba197 and Alberta198 affords hospital committee records the type of protection from admission in evidence more comprehensively canvassed before the Prichard Review, and similar bills have been proposed in New Brunswick and recommended in Ontario,

194 703 F.2d 332 (9th Cir. 1983)
195 701 SW 2d 644 (Tex. 1986)
196 For additional instances, see Rowland, supra note 183.
197 Manitoba Evidence Act, RSM 1987 c. E-150, s. 9
198 Alberta Evidence Act RSA 1980 c. A-21, s. 9
Quebec, and Saskatchewan.199 Advocates' success in advancing such legislation may indicate that the endorsement of the Prichard Review is not essential for the progression of a legislative trend. The review may demonstrate not only the cost that prospective litigants will pay, through denied access to evidence, for the benefit to the community of improved self-scrutiny by health facilities, but also that such benefit may be illusory and that the privilege may be counter-productive of better standards of patient risk-reduction. A statutory rule may be able to be designed, however, that reaches a satisfactory balance of competing claims and interests.200

Responses to crisis

Whether the responses to legal liability identified through the Prichard Review's studies are appropriate or inappropriate, or a service or disservice to patients' and health professionals' interests, are to some extent matters of interpretation. Whether a change in practice is 'defensive medicine,' and whether it is sound or unsound medical practice, or a justified or unjustified use of public resources, can be assessed only through debate among occupants of different vantage points. Similarly, whether legislated privilege from discovery of hospital peer review and risk management committees' documents and reports would be more likely to expose or conceal substandard medical and health administration practice are matters for speculation. Disclosure to a body legally able or obliged not to release disclosures constitutes both revelation and concealment. Those whose goals or interests give them different priorities from those of others are likely to interpret phenomena differently, and to disagree about what phenomena are truly found and what perceptions should weigh in the balance and be influential or decisive in making that determination. The ability to shape what the critical questions are permits some conditioning of the answers.

Some degree of scepticism may be warranted concerning the existence and nature of an alleged crisis in medical malpractice litigation and liability. The doubts that were expressed about whether the 'first wave' of the medical liability crisis of the mid-1970s in the United States was a result of medical practice or insurance industry practice have reappeared. A number of US states have charged that the insurance industry

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199 See generally D.G. Duff 'Evidentiary Privilege for Hospital Quality Assurance and Risk Management: Assessing Statutory Reform' (1989) 47 U. Tor. Fac. LR 526, at 528. This article is based on research originally undertaken for the Prichard Review.
200 Ibid. 540–6
concocted the tort liability crisis of the mid-1980s for its own purposes. Many anticipate that, following vast insurance company losses in the US savings and loan collapse in the late 1980s, premium levels will be raised significantly in the 1990s. The profit goals of commercial medical professional insurance corporations have little application in Canada because the CMPA offers a non-profit, professional self-protection service. The Canadian medical profession monitors US developments closely, however, and anticipates that changes in both medical technique and modes of professional interaction with patients will quickly cross the border. Sensitized by the growing incidence of US suits and the escalating level of damage awards and out-of-court settlements, the CMPA felt it necessary, for protection of its members, to differentiate premiums on the basis of risk of medical specialties, and year by year to raise premiums.

Between 1987 and 1988, for instance, premiums for obstetricians, cardiovascular and orthopaedic surgeons and neurosurgeons rose from $8,250 to $9,800 and in 1991 will reach $13,000. General medical practitioners who provide none of these services, who paid $800 in 1987, paid $950 for 1988 and in 1991 will pay $1,100. While these lump-sum payments are quite modest by US standards, the annual percentage increase appears sizeable. It was, however, below the percentage increase in monetary damages the CMPA paid on behalf of its members, which rose from just under $18 million in 1986 to over $24 million in 1987. It rose to over $25 million in 1988 and by 1989 had reached $37.661 million. This rate of annual increase, over 33 per cent from 1986 to 1987 and over 48 per cent from 1988 to 1989, appears menacing to the medical profession, and may provide the CMPA with an incentive further to build up its contingency funds. At the end of 1986 these stood at $88 million, but an addition to reserves achieved during 1987 primarily through increased premiums brought the total at the end of 1987 to $141 million. By the end of 1989, the contingency fund amounted to $319 million. A profit-making corporation that adds $53 million to its reserves of $88 million in a single year, and two years later has reserves of $319 million, will be considered by its shareholders to have fared well, although those who purchased its services may complain of exorbitance or gouging. Members of the CMPA are, of course, both shareholders and purchasers. They all receive the association’s annual

204 Supra note 202, 41
205 Supra note 203, 36
report, which clearly explains its finances. The explanation for the vast increase in premium-funded reserves was CMPA acceptance of actuaries' advice to accumulate assets to have full funding to meet claims and costs that have not yet been presented arising from activities of members, including former and deceased members, that occurred in past years, and indeed decades. It may be questioned, however, whether the general membership perceives its premiums being accumulated in a sizeable though appropriate contingency fund, or being paid to plaintiff-patients and their lawyers.

It may be observed that, sizeable though CMPA assets may appear, they will be reduced through a number of multi-million dollar damage awards. In fact, however, the incidence of suits successfully brought against CMPA members is low.

The following statistics show the number and outcome of legal claims the CMPA handled between 1986 and 1989 inclusive.

In the context of these statistics there is clearly room for selection of points that are significant. A total of 26 judgments in 1989 against a medical membership numbering 52,418 seems minor, but an annual increase in damage awards of over 48 per cent to exceed $37.66 million

Statistical review of association work

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206 It must be remembered that newborn children's claims may be presented when they reach majority, and that other claims may be brought within the statutory limitation period from when 'the person commencing the action knew or ought to have known the fact or facts upon which he [or she] alleges negligence or malpractice' (Ontario Health Disciplines Act, RSO 1980, c. 196, s. 17).

207 Damages paid on behalf of members include court-ordered legal costs and payments agreed in out-of-court settlements. Legal costs the CMPA incurred in defence of members, in advice, judicial litigation and professional misconduct, fitness-to-practice, and related hearings before committees of provincial colleges of physicians and surgeons, rose from $11,286 million in 1986 to just over $13 million in 1987; see supra note 202, 40. By 1989 this amount had risen to $18.657 million; see supra note 203, 37.

208 Supra note 203, 27
seems justification for concern. It is clear, however, that the present climate of concern in the medical profession brought out in the Prichard Review studies is conditioned not by litigation statistics alone but by a sense of legal exposure and of liability to be the innocent victim of injustice and manipulation. This sense of powerlessness can produce a positive response if the profession improves safety controls of its practices and practitioners. If the price of this is reduced patient access to convenient services, however, choices will have to be made on where the balance between safety and convenience is to be struck. Deciding how the balance is struck and who contributed to the process of striking it is the sort of issue that democratic societies entrust to the dynamics of their political systems.