Mediating Medical Malpractice Disputes: An Alternative to Tort Litigation

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Table of Contents

Introduction *

Case Study - Patient *

Case Study - Physician *

Tort Law & Medical Malpractice *

Purpose of Tort Law *

- **Compensation** *
- **Deterrence/Punishment** *
- **Retribution** *
- **Vindication** *

In the Alternative: Mediation *

- **Incentives** *
- **Implementation** *

Conclusion *

Bibliography *

Introduction

When an individual is harmed as a result of another's actions, their encounter uncovers the breach of an implied contract between them. Autonomy depends on individuals respecting the rights of one another to freedom from interference. One expression of this implicit contract dictates that every person is responsible for the consequences of his or her actions - that if a harm takes place, justice entails accountability on the part of the wrongdoer and vindication for the injured party. These notions are at the

root of tort law, described by one author as:

> A repository of societal values that speak to us about how to live in a crowded community with mutual respect for the interests of others. It protects individual liberty by defining our rights against the wrongful interference of others with our person, property, and other recognized interests.

Tort law has also become a functional vehicle through which wrongdoers are punished and injured parties can receive compensation as well as some sense of revenge. Moreover, the enforcement of accountability is held to act as a deterrent with respect to future wrongdoing. Ideally, the tort system in an isolated incident can achieve compensation, punishment and deterrence. But more generally, it should "provide a means for the community to articulate and enforce social norms regarding the responsibilities of individuals and organizations to each other."

In the medical malpractice context, these ideals persist and the functions of tort law are contained in the process of litigation. The system aims to provide a satisfactory resolution to the injured party and prevent future recurrence of injury.

Unfortunately, the interaction between the available tort system or process and its players has

become much more complex and confrontational. As a consequence, it has become a questionable means for achieving its stated aims of justice. Additionally, the importance of fostering relationships between health care providers and health care consumers is lost within the sphere of litigation.

My intention in this paper is to explore the nature of medical malpractice incidents and how they play out in the civil litigation process. It is my impression that the existing system is inadequate with respect to meeting the needs and interests of the parties involved, particularly physicians and patients. Finally, recognizing the presence of substantial obstacles, I propose that a process whose central focus is mediation creates a less adversarial milieu and one more likely to successfully resolve medical malpractice disputes.

Case Study - Patient

Imagine the following scenario:

> *A 70 year old woman, Ruth McNab, has lived in Nova Scotia her entire life. She moved to Halifax 10 years ago after the death of her husband, to be closer to her daughter Ann, Ann's husband Michael Birch, and their two children.*
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> *About 5 years ago, Ruth started to experience very frequent urination that was sometimes painful and on one occasion she thought she noticed blood in her urine. Her family physician, Kevin Palmer, treated her for a Urinary Tract Infection (UTI) with a course of antibiotics, but her symptoms persisted. The presence of blood in the urine and failure to respond to antibiotics made Dr. Palmer worry about bladder cancer, which prompted him to refer Ruth to a urologist, Dr. Shannon Milton.*
>
> *Concerned about the possibility of cancer, Ruth spoke to Ann and Michael, informing them about her appointment with a urologist. This was the first time Ann's mother had spoken to her about her health. Ruth at 65 was very independent and active, such that any ill-health experiences she dealt with on her own, not wanting to burden her family with unnecessary worry.*

During Ruth's initial visit with Dr. Milton, a urine culture was taken to rule out UTI. It was negative. Dr. Milton then performed a cystoscopy (visual examination of the urinary tract) and biopsy to check for abnormalities including any evidence of Carcinoma (cancer). Bladder distension was carried out to enlarge the bladder and reduce frequency of urination. She found no evidence of cancer, but did find evidence of bladder inflammation, including glomerations (pinpoint bleeding on the bladder wall). Dr. Milton diagnosed Ruth with interstitial cystitis (IC), a chronic condition most common in women, that does not respond to antibiotic therapy and is consistent with the symptoms Ruth had been experiencing, including frequency of urination, urgency of urination, recurring pain and discomfort, and evidence of blood in the urine. Dr. Milton explained that very little is known about interstitial cystitis (IC) and as a result there are no truly reliable treatments. She prescribed a course of oral medication and recommended that Ruth return every six months for cytology (urinalysis that studies the cells for their origin, structure, function, and pathology), but emphasized that it unfortunately might be a condition best treated by Ruth's adapting her mindset and lifestyle to work around it.

After Ruth's initial encounters with Shannon Milton, she was discouraged that there was no cure, but was relieved it wasn't cancer and felt very positive about her experience with Dr. Milton. The doctor spent a great deal of time explaining various procedures and courses of action, making Ruth an active participant in the decisions concerning her

health. Ruth's only complaint was the lengthy wait to get an appointment, so she booked her next 6 month appointment and cytology before she left the office. She then phoned Ann at work to let her know everything was okay.

Over the next few years, Ruth tried oral medications (anti-inflammatory and muscle relaxant treatments), with little success, and attended 3 follow-up cytology appointments, but generally learned to live with IC, maintaining an active lifestyle and healthy diet. Ann was very concerned initially, but like her mother, began to realize that as a chronic, virtually untreatable condition, neither of them could do much about it.

In October of 1998, 2.5 years after her initial referral, Ruth's symptoms worsened in terms of pain and discomfort. She saw Dr. Milton who took a urine culture, which came back positive. Dr. Milton prescribed a course of antibiotics for Ruth's UTI, after which the symptoms resolved to the point where Ruth still had some discomfort and pain, but it seemed less severe and was likely associated with the chronic IC. Ruth felt as though she had more of an understanding of her condition and was functioning well, despite the discomforts. Ruth felt confident that if more severe symptoms occurred again in the future, she would recognize them as different from the day-to-day discomforts.

In September of 2000, Ruth again experienced an increased severity in her symptoms including blood in her urine, but did not want to overreact and took no action initially. Two weeks later, she felt confident that something other than IC was going on, probably another UTI. Ruth called Dr. Milton's office, only to discover that the next available appointment was in three months. Ruth described her symptoms to Dr. Milton's assistant, adding that she thought it was another UTI and probably just needed another course of the same antibiotics. Dr. Milton called Ruth as soon as she was available and went through the symptoms with her, agreeing that it seemed similar to Ruth's previous incident of UTI where antibiotics worked. The blood in her urine was consistent with symptoms of IC. Dr. Milton called in a prescription to Ruth's local pharmacy and encouraged her to be in touch if the troubles persisted.

Having taken the entire course of antibiotics, Ruth's symptoms did not resolve and there was an

increase in the blood in her urine. Ruth was concerned and made another phone call to Dr. Milton's office, but could not get in to see her until January (4 months after onset). Feeling she could not wait, Ruth phoned Ann explaining the situation. Ann was angry and worried and insisted they go to the emergency. When they got there, Ruth was hospitalized and diagnosed with cancer of the urinary tract, at this point untreatable. Ruth died shortly thereafter.

Every outcome in medical malpractice disputes will be different, depending on the actions of the parties, severity of the harm suffered, nature of the circumstances, and the way in which each person involved deals with the circumstances psychologically. This hypothetical case is provided only as a device by which the various perspectives and processes can be effectively illustrated and analyzed.

Suppose Ann's husband, Michael, is a lawyer, whose firm happens to deal in medical negligence law. The events since her mother's hospitalization have escalated rapidly and have been overwhelming and confusing for her, since her understanding was that cancer had been ruled out. Ann was able to have a conversation with her mother's urologist, Shannon Milton, who seemed sympathetic to her mother's condition, but was not forthcoming with respect to why the cancer was not detected earlier. Shannon Milton made it seem as though her hands were tied - everyone has a time to go and medicine cannot always prevent or even prolong the inevitable. Ann feels most frustrated with the absence of explanation and lack of accountability. The reason her mother had initially been referred to a urologist was Dr. Palmer's concern about cancer and yet her cancer was not diagnosed until five years later, too late to do anything about it. Frustrated and angry with her mother's unexplained and untimely death, Ann meets with a lawyer from her husband's firm, Elizabeth Crawford. Following their conversation, Ms. Crawford sends Ann an opinion letter detailing the law and available options.

Claims for medical malpractice generally fall within the scope of negligence since malpractice is rarely intentional. In finding negligence, courts look to a number of factors. Ann, the plaintiff in this situation, must be able to show that Dr. Milton acted negligently in failing to meet the appropriate standard of care in her treatment of Ruth McNab. The standard of care in this case would be established by taking into consideration what other members of the medical profession, specializing in urology, view as common and appropriate treatment in the circumstances. A 1995 Supreme Court of Canada decision outlined the standard of care principle in a medical context:

> It is well settled that physicians have a duty to conduct their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances. In the case of a specialist, … the doctor's behavior must be assessed in light of the conduct of other ordinary specialists, who possess a reasonable level of knowledge, competence and skill expected of professionals in Canada, in that field.

In most negligence claims, the standard of care is that of a reasonable person in the circumstances. Courts have adopted a different means for establishing standard of care in medical as well as other professional contexts "because courts do not ordinarily have the expertise to tell professionals that they are not behaving appropriately in their field." Essentially, it is the reasonable person standard in specific circumstances such that the reasonable person has the medical background and knowledge of anyone else practicing in the same specialty.

Even if it were determined that Dr. Milton acted negligently, Ann as plaintiff also has the burden of establishing a sufficient connection between the negligent act and the injury suffered, namely Ruth's untimely death. The nature of the connection favours the plaintiff in that the negligent act need not be the only thing that caused the injury, but it must have contributed to the injury in some significant way:

> It is not necessary … for a plaintiff to prove positively that, if it were not for the negligent conduct, the accident would have been prevented; it is enough to show that the negligent act contributed to the accident.

Moreover, there may be a number of reasons the plaintiff was injured, and the Supreme Court of Canada has held that "as long as a defendant is *part* of the cause of an injury, the defendant is liable, even though his [or her] act alone was not enough to create the injury."

Another approach adopted by the courts with respect to causation has to do with proof. In the medical malpractice context, the defendant physician often has access to more factual information because of the scientific and medical nature of the situation. In the 1990 Supreme Court of Canada judgment of *Snell* v. *Farrell*, Mr. Justice Sopinka held that a common sense approach to causation is appropriate and that causation can be inferred where the defendant produces no evidence to the contrary and there are proven facts that would lead a reasonable person to such an inference.

Other elements that need to be established in a negligence action include the existence of damage suffered, the establishment that a duty of care was owed by the defendant, and finally, that the damage suffered was not so remote from the negligent act as to make liability unfounded.

> *Elizabeth Crawford's letter to Ann suggests that their greatest obstacles will be establishing a breach of the standard of care and establishing causation. Ideally, they*
>
> *want to show not only that Dr. Milton's treatment of Ruth McNab was inappropriate in the circumstances, but had the treatment been appropriate, that the cancer would have been detected earlier - early enough that it could have been treated. Because Ann was not privy to the details of her mother's ongoing treatment, they will need to examine Ruth's medical records and try to fill in some of the gaps between Dr. Palmer's initial referral*
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> *and the diagnosis of cancer five years later. There may not be a duty of care on the physician to insure follow-up cytologies were done. They will need to gather expert evidence to discover whether or not earlier diagnosis and intervention of the cancer would have resulted in a better outcome.*

If Ann chooses to take action against Shannon Milton, one option is to file a complaint with the College of Physicians and Surgeons of Nova Scotia [hereinafter "College"], a governing body that regulates physician licensing and professional conduct. The College holds physicians to the ethical standard set by the Canadian Medical Association in their Code of Ethics. Choosing this route would involve the following process:

> When the College receives a written complaint against a physician, the usual process is for a copy of the letter to be forwarded to the physician who has 30 days to respond. A copy of this response is usually sent to the complainant for comment. The physician is then permitted a final response.
>
> All written complaints concerning discipline issues are forwarded to the Investigation Committee for review, investigation and disposition. This Committee may request additional information or they may wish to interview the physician and/or the complainant.
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> At the completion of their investigation, the Committee may dismiss the complaint, attempt to resolve the matter informally, offer mediation, counsel and/or caution the

physician, reprimand the physician (with consent), require the physician (with consent) to undergo treatment or re-education or refer the matter to a Hearing Committee.

Once a complaint is referred to a Hearing, the College becomes the formal complainant and prepares the charges. The Hearing process is similar to a trial. Physicians are represented by lawyers and complainants are usually called as witnesses to testify. In some cases, the matter may be resolved by means of a Settlement Agreement in which case a Hearing is not necessary. The Hearing Committee can impose penalties ranging from a reprimand to removal from practice.

The College is a disciplinary body, but "it cannot find a physician guilty of negligence and/or order the physician to pay a patient financial compensation." Ann would have more success in terms of receiving compensation by proceeding via the civil litigation process. Using the court system to resolve such a dispute also allows for the potential of finding someone at fault or responsible for the harm suffered in a binding decision. Having her 'day in court' might be all Ann needs to feel that the events leading up to her mother's death have been recognized and accounted for. If she chooses to litigate, the first step is to file an originating notice and statement of claim with the court against Shannon Milton, for negligence resulting in the wrongful death of Ruth McNab.

Case Study - Physician

Almost all physicians in Canada are members of the Canadian Medical Protective Association [hereinafter "CMPA"], "founded in 1901 by a group of Canadian doctors for their mutual protection against legal actions based on allegations of malpractice and negligence." Membership payment goes into a reserve fund, used for the defense and settlement costs of physicians involved in civil actions based on their professional conduct. "A member physician is eligible for assistance for all claims arising out of professional work done during active membership, regardless of when claims are made."

Shannon Milton had not yet read her CMPA membership information in detail. However, after being served with notice that Ann Birch had commenced legal proceedings against her, she knew from the experience of colleagues that she should contact them right away. Shannon's mind had been on other things when the process server presented her with

notice in the middle of her afternoon clinic that day. She had a meeting with the Dean at four o'clock, who wanted her to chair the Equity Committee (one more thing she did not have time for but wouldn't be able to say no to) and one of her patients on the ward needed to see a surgical consultant who wasn't answering his pages. On top of work, her daughter Lizzie's soccer team had a playoff game she had to get to. It was not that she had forgotten about Ruth McNab - a pleasant and interesting patient who had regretfully died recently from cancer of the urinary tract. In fact, upon Ruth's admission to the hospital, Shannon had a conversation with Ruth's daughter. Having been informed of her mother's untreatable and terminal condition, Ann Birch was understandably angry, upset, distracted and preoccupied with the emotional trauma and tragic circumstances. Shannon had attended to her responsibilities as Ruth McNab's physician and thought she had left the doors of communication open, should Ruth's daughter have any questions or concerns.

Upon being served, Shannon's first instinct was to phone Ann Birch and arrange a meeting. Maybe there had been some misunderstanding or miscommunication she could clarify. Had she been less thorough than normal? Did the office neglect to arrange a follow-up cystoscopy? Had she made a note on Ruth's chart that they should?

After the soccer game, Shannon drove back to her office to check Ruth McNab's chart. Ruth's history was fairly typical of IC patients - chronic, difficult to treat symptoms, some of which resemble those of bladder cancer. For this reason it is important to perform routine cytologies in order to rule out cancer. According to the chart, Ruth had come in for three follow-up cytologies after her initial visit, but none were performed in the last couple of years. She had a UTI in 1998, which resolved with a course of antibiotic therapy. Shannon should have arranged another cystoscopy and bladder biopsy then, but probably assumed she'd had a recent cytology done or was booked for an upcoming appointment. Frustrated, embarrassed and concerned, Shannon decided she would phone Ruth's daughter the next morning to sort things out. In the meantime, she decided to check the CMPA website for membership information and came across the following advice:

> If you are faced with a serious complaint or a threat of lawsuit:
>
> 1. Notify the Association by mail, telephone or facsimile at once. Send complete, concise information. Click here for our mailing address, telephone and fax numbers. DO NOT contact the CMPA by email;
> 2. Wait for a reply from the Association before taking any further steps;
> 3. Be sure your clinical records are secure;
> 4. Do not consult a lawyer without instructions from the Association. The Association does not accept responsibility for the payment of legal expenses incurred without its prior approval;
> 5. Do not answer any letters of complaint from patients, lawyers or others without first receiving the Association's advice.

Though patients are named as the injured parties in medical malpractice suits, the process of litigating itself often has a detrimental effect on the patient and/or their family and the treating physician. According to one author, the common reaction to a lawsuit from the physician's perspective can be quite devastating:

> It matters not whether the suit is titled a professional liability action or a professional negligence suit, the physician knows it is staining his [or her] ability with the ultimate pejorative, *malpractice*. Being accused of irresponsibility cuts to the core of the physician's sense of self and sense of commitment to patients. Feelings of devastation, surprise, and intense anger are the most common immediate reactions.

Buckner goes on to describe the way in which a physician's practice can be negatively affected when they are attempting to cope with the significant psychological impact that an allegation of malpractice has. "The physician begins to labor over clinical decisions, to develop over-utilization of diagnostic and treatment modalities and ineffectually evaluate his [or her]

findings."

Tort Law & Medical Malpractice

By its nature, the legal structure in Canada is adversarial, made to determine right vs. wrong, winner vs. loser. The process is founded on the notion "that contested, oppositional presentations of 'facts' will best reveal the truth." In tort litigation, parties to a dispute are provided a "neutral forum within which they can resolve their differences and exercise their rights without government interference."

In tort law, the primary goals are to put the injured party back where they would have been had the tort not occurred, by way of monetary compensation; to punish the wrongdoer by holding them accountable for their tortious or negligent actions; and to deter future injurious events. Due to the nature and complexity of factual situations, like the hypothetical case study above, it is often difficult to determine whether there is a clear right and wrong, winner and loser. As a result, many medical malpractice disputes do not fit neatly into the tort structure, and the objectives sought are not satisfactorily achieved, thus disputes go unresolved.

Litigation is the process through which tort law operates, in the surroundings of law offices and courtrooms. Because the majority of Canada (excluding Quebec) operates using the common law system, judge-made decisions set precedents and establish rules of law. In following established precedent, litigation outcomes are generally reliable, consistent, and binding. Lawyers working within the structured process are likely familiar enough with previous case law

to give clients a fair prediction of their chances at a successful result, measured primarily in monetary value. As a result, if the specific circumstances of a case correspond appropriately with the established rules of law, tort litigation may very effectively achieve its stated purpose. For the numerous medical malpractice disputes whose facts do not fit the traditional judicial structure, it may be appropriate to seek a more suitable alternative.

Super-imposed on the complexity of the circumstances in each case and the oppositional nature of the legal process, is the impact of substantial use of the system. The ideal situation in an adversary system involves the presentation of various evidence and supporting arguments to an impartial fact-finder, who then establishes - based on the rules of law - whether or not harm has taken place, if it has, whether or not the defendant ought to be held accountable, and if they ought to be, how to adequately compensate the injured party. In other words, the system propounds to achieve justice. The process is well-defined and has noble aims, but lacks the flexibility and accessibility that is necessary for accommodating the volume and complexity of claims.

Lawyers play the role of advocates or representatives, ideally allowing for a more even playing field between disputing parties, such that the eventual outcome is based on the substance of their arguments. The unfortunate reality is that hiring lawyers does not necessarily place parties on an even playing field since lawyers cost money and not every person can afford representation. In the medical malpractice context, physicians pay membership fees to the CMPA, who in turn provides them with full protection in the event of a complaint or lawsuit. The 1999 CMPA *Annual Report* financial statement reports the following with respect to net assets:

> **Reserved for claims** is by definition, all net assets other than capital assets that are held against the anticipated cost of claims in future years. Based on actuarial evaluation, the Reserved for claims of $1,835 million is sufficient to cover all outstanding liabilities incurred on work performed up to December 31, 1999.

The CMPA clearly has significant resources from which to draw when providing protection and representation to physicians. Their pockets are almost inevitably deeper than those of prospective plaintiffs, thus defendant physicians will be more easily and suitably represented. Furthermore, because lawyers are motivated to act solely on behalf of one party, they are seeking the best outcome for their client, not necessarily the truth:

> Courtrooms, lawsuits, and litigation are not about "truth;" they are about winning (and losing). And the way to win is to get "your truth" accepted rather than the other side's. Tomorrow, "your truth" may be exactly the opposite of what you argued today. This is

> what lawyers do despite their claims to the contrary. They argue what will win, not necessarily what is "true".

CMPA's mandate is the protection of physicians and maintenance of a vigorous defence standard. In the litigation context, they are clearly in a favorable position when set against almost any plaintiff. It is not only their financial position that places the CMPA in an advantageous position with respect to litigation. One significant advantage for the CMPA is having established law firms on which to rely for all their needs. In doing so, member physicians are represented by lawyers who have become virtual experts in both medical malpractice litigation as well as in several fields of medicine. Given the nature of medical malpractice disputes, a lawyer's expertise will be insufficient and expert evidence becomes a necessity since the expanse of knowledge is not accessible to those outside the profession. As a result, physicians in the specialty area at issue in a claim will be called for examination during the discovery process and as witnesses at trial. These physicians are undoubtedly colleagues of the defendant physician and likely to avoid testifying against him or her:

> The CMPA can depend on a well-groomed stable of articulate physicians whose bias is to produce a defence opinion. These medical specialists will, of course, decline to comment if they see the claim as indefensible. Otherwise, their expressed opinion will likely be unequivocally supportive of the defendant.

All these elements contribute to the dominant position of the CMPA in medical malpractice disputes, where success is dependent on expert evidence and being equipped to handle the financial burden of the litigation process.

On top of the legal fees parties to a litigation have to pay for their representation, Canadian court costs are very expensive. "It has been estimated that in Toronto, … the total legal bills to all parties in an average General Division lawsuit (including those that settle before trial) may easily amount to between $40,000 and $50,000." Exorbitant costs prevent civil litigation from being a process that is widely accessible, since only those parties with deep pockets can afford to litigate. One response to the problem of accessibility has been the implementation of contingency fees, but it does not resolve the dilemma since only cases that are most likely to result in substantial pay-outs to the plaintiff will be taken on in the first place:

> Though all Canadian provinces, with the exception of Ontario, permit contingency fee arrangements, this is of little comfort to potential plaintiffs whose claims are relatively modest and are unlikely to be of interest to a lawyer on a contingency basis. As the *Prichard Report* notes, legal counsel routinely discourage claims involving predicted damages of less than $100,000 (Can.)

Another procedural downfall of civil litigation is time delay, due to the backlog of cases. Twelve years ago it was estimated that a serious claim could take three years to reach the trial stage. In 2001, the delay is probably closer to five or six years. One might question whether the financial burden and lengthy time commitment would be worthwhile for someone like Ann Birch, in terms

of fulfilling the unmet needs that motivated her to initiate litigation.

Procedural impasses like cost and delay contribute to the inefficiency of the adversary process, but they are not the only obstacles to satisfactory resolutions. Limiting this exploration to the context of medical malpractice, there exist substantive reasons for the inadequacy of tort litigation in resolving disputes.

Communication or lack thereof is central to almost every medical negligence dispute, and because the adversary process is oppositional in nature, effective communication between parties becomes stifled once they enter the system. As a result, personnel of the system, rather than parties to the dispute, determine what the respective needs are and how best to meet those needs. Allowing the tort litigation system to dictate the process of resolving medical malpractice disputes rather than disputing parties themselves is perhaps at the root of its inadequacy in this context, both from the patient/complainant perspective and from the physician/defendant perspective.

Purpose of Tort Law

It is useful to look to the stated aims of tort law as well as to the case study in examining what a patient or complainant in a medical malpractice suit is trying to accomplish. The functions of tort law are purported to include compensation, punishment, specific and general deterrence, vindication, and retribution. It is reasonable to assume then that individuals who choose to pursue tort claims do so with the belief that some if not all of these objectives will be met in doing so. The reality of tort law unfortunately does not measure up to its theoretical aspirations:

> Law and everyday life confront each other in complex ways in these cases. Plaintiffs' attempts to mobilize the legal system on their behalf - to air their injuries, to require their perceived injurers to respond to their charges in public - are met by lawyers' and judges' desire to transform their legal claims to everyday financial transactions. What begins as personal tragedy - however appropriately or inappropriately linked to a product or harmful event - is translated into alien legal practices.

It is reasonable that in the interest of maintaining some level of efficiency and expediency in the procedural structure, courts must deny parties some concessions, such as flexibility with respect to remedy. However, in certain contexts, the focus on expediency seems to overwhelm the goal of achieving satisfactory resolutions within the civil litigation system. Perhaps in medical malpractice disputes, alternative processes could be used in conjunction with litigation in order to better realize the necessary balance between efficiency and successfully meeting the interests of the various players involved.

- **Compensation**

Tort law aims to place the injured party back where they would have been had the tortious or negligent act never occurred. Necessarily courts are limited in this regard as compensation is restricted to monetary awards. Greater harm, injury, damage equals greater monetary compensation. Courts are reluctant to get involved in individual disputes with respect to following up on enforcement of orders. It is more efficient for them to simply assign items of damage a monetary value, award judgment, and move on to the next case. The obvious difficulty lies in establishing the monetary worth of various injuries. Actuaries are well paid to figure out loss of future earnings, medical expenses, and cost of future care, all the while taking into account factors like mitigation, life expectancy, tax, inflation, and general contingencies. As if it weren't complicated enough, courts have categorized damages to account for non-pecuniary losses like pain and suffering, loss of enjoyment of life, and expectation of life. The reasoning and efforts behind creating a workable system within the confines of monetary compensation are commendable. However, restricting remedies to dollar awards is fundamentally problematic in the context of personal injury and medical malpractice because money does not adequately compensate for the harm that has been suffered. For torts such as damage to property, courts will award equitable remedies where damages are inadequate, yet in the context of personal injury, even for non-pecuniary damages, harms are quantified in terms of dollars because courts are hesitant to become involved in a dispute and take on a supervisory role.

Deborah Hensler writes: "plaintiffs in ordinary tort litigation are at least as interested in "telling their story" as they are in collecting monetary damages." If tort law is founded on the principle that an individual who causes harm to another person ought to be held accountable for their actions, and if tort law further claims to achieve the objectives of justice and retribution, it is not surprising that it fails to achieve such a variety of goals when restricted to a single remedial tool. Harms suffered in medical malpractice incidents have a number of dimensions that are impossible to place a dollar value on; therefore, making compensation a purely monetary structure is an inadequate means by which to achieve reparation.

It may be that restricting remedies to monetary awards is reasonable in the interests of court efficiency and ensuring compensation is received by the injured party, even if money does not effectively address the actual harm suffered. Another problem arises, however, because the statistics demonstrate that casualties of medical negligence are rarely compensated sufficiently, if at all. In 1990 a report was prepared by J. Robert S. Prichard, chair of the Conference of Deputy Ministers of Health. The report outlined findings and recommendations after a review was conducted with respect to the state of medical liability and compensation in Canada. Finding #15 in the report stated the following:

> Despite the substantial growth in the frequency of successful civil liability claims against physicians since 1971, the percentage of persons suffering health care injuries as a result of negligence who receive compensation remains modest and is certainly less than 10 percent of potential viable claims.

People have the impression that there is a 'litigation explosion' and that droves of individuals are filing frivolous lawsuits, but the reality demonstrates otherwise. Physicians are concerned about their "vulnerability to lawsuits and contend that access to civil litigation is too liberal." This impression overshadows the reality that the vast majority of negligence-related medical injuries are not compensated because plaintiffs generally do not have the financial means to access the justice system. Commenting on the distressing reality, Bernard Dickens writes,

> Contrary to prevailing beliefs among health professionals, there is no crisis arising from successful medical malpractice claims, and indeed the true litigation crisis is that an unacceptably high number of recipients of medical services who are avoidably injured by them receive no or inadequate compensation.

Those who do receive compensation have the 'perfect case' legally, or enough money to afford legal representation. Mitchell and McDiarmid recommend the establishment of a Patient

Protective Association (PPA), a reliable support system that acts in the interests of patients, both financially and legally. A PPA could act as a counterbalance to the legal force of the CMPA, thus allowing greater access to justice for injured parties.

- **Deterrence/Punishment**

From the complainant's perspective, part of their motivation in taking action against their health

care provider is to ensure that the same injury or negligence is not inflicted on someone else. With respect to public policy, there is tremendous interest in a system that aims to improve overall quality care. The question is whether the process of tort litigation is the most effective means by which to satisfy the interests of deterrence. Theoretically, potential tortfeasers will be more careful and less likely to be negligent with the threat of liability looming over their heads. In most incidents, including medical malpractice, liability is equated with guilt or wrongdoing of some sort. For physicians, a finding of

liability entails significant damage to reputation and may affect their practice and/or future employment opportunities - undesirable events that optimally should encourage prevention and deterrence.

There are at least two reasons why threat of liability is an ineffective deterrent under the current system. The first involves the effect of tort litigation on the defendant physician. Tort litigation focuses on individuals and individual events, providing a specific remedy to a single wrongful

act of the past. Rarely is the question of why the negligence occurred in the first place explored or answered in the civil litigation process. Rather than look to underlying systemic reasons for medical negligence, the focus is on establishing the existence of a particular negligent act that is causally linked to the harm suffered. It is similar to criminal law in that tort law narrows in on the wrongdoer and punishes that individual by having them provide compensation to the injured party. Effectively, this approach might prevent future malpractice by the specific defendant physician, but it is difficult to predict the overarching influence it will have on the general medical community. Ideally, an effective general deterrent should prevent future incidents of medical malpractice by improving the underlying system to ensure that similar errors don't occur

in the future. By concentrating on a specific individual and event in the past, any systemic cause is likely to be overlooked. Dauer and Marcus contrast the torts system, which "attaches serious consequences to typically infrequent events; reaches binary win-or-lose outcomes from a process of more-probable-than-not" with what they argue is necessary for successful error prevention:

> Acceptance of errors as windows into "process upsets" or "process inadequacies," which when taken in a comprehensive understanding of outcomes and deviations can illuminate opportunities for improvement.

Medical malpractice litigation is more adequate as a specific deterrent because the focus is on isolated incidents. However, considering the adverse effect of litigation on defendant physicians and the reality that the incidents are often random events, even as a specific deterrent, the efficacy is questionable. It has been demonstrated that "physicians who become involved in one malpractice claim face an elevated risk of incurring a second claim during the year following the date the first claim was filed." Perhaps those physicians are simply incompetent, but there may be additional factors that have a negative impact on even a competent physician's practice. As illustrated by Dr. Shannon Milton's experience in the case study, the plaintiff in a medical malpractice litigation is not the only party who experiences emotional trauma:

> Physicians who are under the malpractice gun are isolated from both their patients and their professional colleagues; they feel vilified by the accusations and the personal invective that litigation requires; they are distracted and engage in excessive rumination, to the detriment of timely and effective medical decision-making; and they experience a marked loss of professional self-confidence. Litigation causes stress; stress causes dysfunctional behaviors; and these behaviors can contribute to the making of additional errors.

Ideally, a medical malpractice resolution process should deter particular negligent actors from recurrent negligent acts in the future and should also provide general deterrence to the medical practice such that the overall quality of care and practice improves. Tort law's focus on isolated events, emphasis on punishment, as well as its confines of monetary remedy seem to be limiting factors on its adequacy as a general deterrent. "Physicians … are moved by the threat of malpractice liability to avoid the risk of liability rather than to avoid the risk of injury." Moreover, because physician defendants are adversely affected psychologically by the process of litigation, their professional conduct is also adversely affected,

restricting the potential of specific deterrence.

In their defence, the CMPA does act in the interests of general deterrence with respect to medical malpractice, by providing information about specific incidents, statistics on high risk specialties and procedures, etc. On the other hand, CMPA's role as a liability insurer limits the ability of tort litigation to act as a deterrent. Physicians pay substantial fees for their CMPA memberships and in return are provided the promise of protection in the event of a complaint or legal action against them. The notion behind deterrence in tort law is that the wrongdoer is discouraged from future negligence when they are punished by having to pay the injured party compensatory damages. If the defendant physician is represented by a funding third party, they are unlikely to feel any personal impact in a judgment against them. Insurance premiums may go up, but they do so across the board of particular specialty areas, not for individual physicians. Moreover, most provincial professional associations that represent physicians have negotiated agreements with the government, allowing them to fund some percentage of every physician's CMPA dues. The Nova Scotia Medical Society, for example, in their negotiated agreement, enables physicians to receive up to a 90% rebate on their CMPA dues after the first $1,500, depending on specialty area. If deterrence is meant to result by way of punishment, some disciplinary action seems like a more effective means by which to impact the actual wrongdoers. The College is a disciplinary body, but does not perform the function of awarding compensation.

Although civil litigation is not the most effective deterrent, other forms of deterrence certainly exist with respect to medical negligence. Aside from bodies like the CMPA working to continually educate their members,

> Physicians have numerous reasons other than the threat of a tort action for maintaining a high standard of care: an emotional tie with the patient, self-esteem, a professional desire to maintain a good reputation, a desire for respect from colleagues and sanctions from physicians' provincial governing bodies.

It is important to realize that physicians, who are humans, will not stop making mistakes. In an attempt to decrease the occurrence of preventable error and improve the quality of health care output, it may be reasonable to use a tactic other than frightening physicians with threats of litigation in order to ensure that an adequate standard of care is being met. Instead, it is appropriate to examine the system within which errors occur in an attempt to create widespread deterrence and improvement.

- **Retribution**

Tort law aims to provide adequate compensation to injured parties when a finding of fault or negligence is made, but advocates of tort litigation also assert its ability to resolve some of the issues associated with the psychological dimension of disputes. For the complainant/patient in a medical malpractice dispute, harm has been suffered and where someone is responsible for that harm, the injured party seeks not only compensation, but some sense of justice or vengeance, acknowledgment of accountability, possibly an apology. It is unlikely that a court would order an apology, but tort law does provide a forum wherein an injured party is provided some recognition that they have been wronged and judgments against defendants allow for some sense of revengeful satisfaction. Allen Linden suggests that without a medium like tort law, "some victims of wrongful conduct might once again take up clubs and axes to 'get even' with their aggressors." He suggests that the arena of tort litigation satisfies the "symbolic quest for human justice":

> We do not know very much about the psychological reasons for the mystique surrounding the dispensation of human justice according to law. We do know, however, that for most people the process exudes an aura of dignity, humanity and impartiality. There is little

> danger that it will ever be replaced by computers providing mathematical answers to our problems.

I agree that there is a very human aspect to the resolution of disputes that is not easily structured, but disagree that tort law is the forum that best allows for a satisfactory resolution.

In some cases, an appropriate remedy will involve a negligent physician being subject to disciplinary action. Because tort law is handled in the civil litigation system, the only punitive remedy is quantified monetarily and is unusual in cases of negligence since the wrongful acts are rarely accompanied by malicious intent. However, an alternative exists in the College, which acts as a disciplinary body and fields complaints "initiated by (a) any official body corporate or association; (b) the Registrar; or (c) any other person." The Investigation Committee has the discretion and authority, subject to statute, to deal with complaints both formally and informally

and thus may produce a more satisfactory outcome than litigation. The College does not have

the authority to order physicians to pay complainants monetary compensation, thus for both compensation and disciplinary action, both avenues will have to be pursued. Depending on the allegations in a civil lawsuit, the Registrar may initiate a complaint against the offending physician. Otherwise, the plaintiff to a civil action may have to initiate a separate complaint with the College if he or she seeks disciplinary retribution.

Patients or their families file claims against health care providers for several reasons other than seeking revenge. Rather, when harm has been suffered, often those affected by the harm are at least as interested in finding out why it happened as they are in receiving retribution. The case study is structured to illustrate that Ann's motivation for meeting with a lawyer goes far beyond a desire to have someone pay for the loss of her mother. The absence of information and explanation contributes substantially to her feelings of anger and frustration. In Ann's mind, her mother was referred five years ago to a urologist because her family physician was concerned about cancer. If cancer was the reason for her referral, how could it be that it was not detected until several years later when it was untreatable? Without dismissing the evidence of below-standard care in this scenario, it is possible that had Ann been made privy to a more complete history of her mother's treatment throughout the five years, including why the diagnosis was not made earlier, her feelings entering the lawyer's office would have been different. Dauer and Marcus examine the reasons that prompt the initiation of litigation in iatrogenic injury incidents and cite a study that investigated the motivation to litigate for parents of children with perinatal injuries. The results were as follows:

> 33% were advised by a third person to do so;
>
> 24% The doctor was not completely honest, or lied;
>
> 24% Needed money for the child's future care;
>
> 20% Could not get anyone to tell them what happened; and
>
> 19% Anger, revenge, or to assure it did not happen again.

The medical profession is a relied-upon, trusted establishment, depended upon for necessities of life. When something goes wrong that can be attributed to the care provided by that establishment, there is an implicit breach of trust and fiduciary duty. Consequently, motivations that prompt individuals to seek resolution in medical malpractice incidents are complex and varied. Moreover, monetary compensation

will not always be a satisfactory remedy for the problems underlying a dispute.

A significant number of medical malpractice actions seem to arise out of some misunderstanding or miscommunication - a feeling by the complainant that somebody is accountable, but nobody has assumed responsibility. In his exploration of medical malpractice from a plaintiff advocate perspective, Henry Wachsman observes: "of the thousands of cases, … we can think of very few in which the hospital or doctor involved simply came forward and admitted the mistake, apologized, and tried to accommodate the victim." This leads one to wonder why, considering the fiduciary nature of a patient-doctor relationship, in a field like most where human error is inevitable, physicians would not be forthcoming about mistakes or oversights regarding their care and treatment of patients. In the case study, for example, Shannon Milton's first instinct upon being confronted with potential litigation was to contact Ann Birch, but she refrained from doing so. Refrained, because the CMPA's instructions were to "not answer any letters of complaint from patients, lawyers or others without first receiving the Association's advice." It is not necessarily the CMPA's intention to prohibit all communications between doctor and patient, rather they wish to prevent admissions of liability. However, their instructions suggest a material risk in continuing communications and physicians may have difficulty determining what is or is not safe to say. As a result, communication ceases.

Sandra Gilbert provides a detailed account of her encounters with both medical and legal professions surrounding the death of her husband, which occurred due to medical negligence. Her story is indicative of the way in which medical malpractice disputes occur and the issues that surround them. In one of several meetings with her lawyer, Dan Kelly, Gilbert is told a story about another client whose wife came out of routine surgery in a coma and died two months later. When the client confronted the doctor to ask what happened, the doctor provided no explanation except to say, "it was God's will":

> "God's will! Well, the man came to *me*, had to find out what happened to his wife. And we deposed the people who were in the OR, found out what everyone knew all along. The perfusion machine - that's a machine that keeps the patient breathing during the surgery - the perfusion machine ran out of oxygen. Someone just forgot to fill it. And you only have two minutes in a situation like that, then she's brain dead. Comes out of there comatose."
>
> …"Happens all the time. But this guy was a good Catholic, a patron of the hospital. If the doctor had leveled with him, he wouldn't have sued."
>
> And why *don't* physicians "level" more, I wonder. Pride? Self-deception? Or, in fact, the fear of precisely the kind of lawsuit that Kelly says this doctor could have avoided by telling the truth?

In Canadian law, for a court to make a finding of negligence, it must be shown that the appropriate standard of care was breached. A physician who acknowledges their mistakes is effectively admitting liability in the context of tort litigation. As a result, physicians are unlikely to be forthcoming about deviations from quality health care even when the errors are inadvertent and the physician's desire is to be forthcoming. It is difficult to imagine that in a system designed to resolve disputes, one of the first steps involves effectively putting an end to communication between the parties. Wachsman endorses a change in sensibility on the part of physicians, "so that malpractice happens less frequently, and so that when it does happen, it's dealt with quickly, not covered up to protect the doctor." However, it will be difficult for sensibilities to change when physicians feel they are under the threat of litigation for admitting mistakes.

- **Vindication**

The adversary system professes to establish the "truth" - who is right and who is wrong through the

process of litigation and an eventual trial. I have already discussed the ways in which this approach might inadequately deal with medical malpractice incidents, but it does create incentive for parties to pursue litigation, particularly a defendant physician:

> The physician's primary aim is to achieve total and absolute vindication. He [or she] wants to regain an unbesmirched reputation, to be labeled 'one of the good guys' by the public and his [or her] peers. … The physician has accepted paying for professional liability insurance with appropriate coverage limits as a cost of doing business. Therefore, the idea that going into court may result in a hefty award to the plaintiff, does not deter the goal of vindication.

A process that does not clearly determine right and wrong is unlikely to grant full vindication. Also in the Canadian physician's interest is a protective association (CMPA) with a defence philosophy that asserts: "Professional integrity is first and foremost; No negligence = No settlement; [and] Protection independent of physician's history or track record." However, it is misleading to suggest that the process of tort litigation, as it currently functions in the arena of medical malpractice, is an expedient and reliant method by which to exonerate oneself.

Realistically, if a malpractice litigation gets to trial, it takes years to do so. In 1999, 1,432 pending legal actions against CMPA member physicians were resolved:

- 9% went to trial (7% were judgments for the physician and 2% judgments for the plaintiff)
- 63% were dismissed, discontinued or abandoned (without trial or settlement)
- 28% settled

The actions that are dismissed may represent those without merit, in which case, physicians will be awarded some sense of vindication. Dismissal, discontinuance or abandonment may also result in cases where the plaintiff is exhausted by or cannot afford the process, or where the plaintiff's legal representative is of the mind that the costs of litigating will outweigh any potential award, thus it is not worth pursuing. Though these make up the majority of resolved claims, one should not assume that because they did not result in settlement or trial that there was no negligence. It is clear from both the *Prichard Report* and the Harvard Medical Practice Study that very few victims of medical negligence receive any compensation. Elgie, Caulfield and Christie utilize both studies in their examination of the tort of medical negligence. They note that authors of the Harvard Study, "concluded that only one negligence claim is made for every 7.5 injuries caused by negligence." As mentioned earlier, finding #15 of the *Prichard Report* established that less than 10% of plaintiffs with viable claims receive payment. In my opinion, based on this evidence, one cannot conclude that dismissed claims mean no harm was done, thus physicians are not exonerated in the true sense.

We are left with the very few claims that proceed to trial and the many that get settled. It may be true that the adversary system is appealing to the physician who feels unfairly accused of

negligence or malpractice, because at trial a judgment for the physician is tantamount to total

vindication - a restoration to their reputation. However, since so few claims make it to trial and when they do it is years between initiation of litigation and of final judgment, compounded with the detrimental affects malpractice litigation has been shown to have on physicians, it becomes a much less appealing option. Because most medical malpractice claims settle, connoting compromise, there may be a way in which monetary compromise can occur without the costs and delay of litigation, in a flexible forum that

allows for other important interests of disputing parties to be satisfied.

In the Alternative: Mediation

> Mediation is a decision-making process in which the parties are assisted by a third party, the mediator; the mediator attempts to improve the process of decision-making, through use of a variety of skills and techniques, to assist the parties to reach an outcome to which each of them can assent.

Advocates of mediation maintain that aspects of medical malpractice disputes are of such a complex and variant nature that they cannot be adequately addressed within an adversary process that is restricted to monetary remedies. I have already addressed a number of reasons why the adversary process is limiting with respect to dispute resolution. Its limitations are problematic in the context of medical malpractice because the disputing parties have unique needs and concerns that are not sufficiently met, if at all, by the civil litigation process. The limitations I have addressed thus far can be linked to certain inflexible aspects of the adversary system:

- Solutions are created and imposed by a third party decision-maker, taking any potential control over remedy out of the hands of disputing parties;
- Parties to a dispute are set in opposition to one another;
- Problems in disputes are made to fit the confines of the rules of law. If they do not fit, a final resolution at trial is not achieved, even where a dispute still exists;
- Expression of each party's story or argument is limited in two ways:

1. It is made to fit within structured legal rules; and
2. It is left in the hands of representative legal counsel to explain and perhaps distort; and

- Remedies are restricted to compensatory monetary awards, which suit the courts' desires for efficiency.

Rather than dispute resolution lying primarily in the hands of disputing parties, the Canadian legal structure dictates what the dispute is, what the needs are that ought to be met, and how best to meet them:

> Procedural justice indicates that litigants approach the court expecting what tort theory - and 'law' - promise: an individualized dispute resolution process in which they will have an opportunity to present evidence that they have been harmed as a result of the defendant's wrongful behaviour. What they experience, however, is the everyday practice of the legal system: a highly bureaucratized process, … in which individual plaintiffs - and the larger community - have little role to play.

The goal is to meet the needs of disputing parties, rather than those of judges and lawyers, thus mediation may be a viable alternative to litigation in the medical malpractice context. In addition to being more expedient and less costly, mediation has the capability to be very flexible in both process and remedy:

> For its part, mediation, when properly employed, can be private, integrative, safe, nonjudgmental, and flexible in scope, process, and outcome. It can be a safe harbor with therapeutic potential, and can offer its participants the opportunity to address the source as well as the consequence of the immediate problem.

Due to the nature of mediation, the specific and unique grievances and concerns of both patients, or their families, and physicians can be directly addressed and more appropriately remedied.

Some might argue that mediation, though a viable alternative in some arenas like family law, is inappropriate in the context of medical malpractice:

> The parties in a malpractice claim lack an interest in maintaining a long-term relationship. The plaintiffs typically have suffered serious injuries and are seeking large sums in compensation. Physicians are concerned with their reputations, and often are unwilling to admit any liability on their part. Any future relationship is rarely anticipated between the parties.

It may be true that patient and physician have dissimilar objectives in a medical malpractice dispute, and that in particular circumstances parties will have no interest in maintaining an doctor-patient relationship. However, it is certainly the sort of relationship that ought to be fostered generally. There is an implicit contract entered into between physician and patient, but the contract is such that one party relies heavily on the other for performance of their services - creating an imbalance of power. It is likely in the public interest to encourage trusting, communicative relationships between patients and their health care providers, since individuals do and will continue to depend on physicians' care and expertise. Patients must feel secure and confident that health care providers will keep them informed and aware with regard to their treatment, respecting their decisions as autonomous persons. Mutual understanding and agreement seems more likely to occur in a setting where the development of trusting and communicative relationships between physician and patient are encouraged. A patient may want nothing more to do with the physician against whom he or she has a grievance, but it would be detrimental to discourage doctor-patient relationships generally.

Secondly, the benefits of mediating run above and beyond satisfying the sole interest of maintaining long-term relationships. For the patient/complainant seeking explanation and accountability, the mediation environment that is voluntary, confidential, and facilitated by an impartial mediator interested in meeting the needs of both parties, is more likely to fulfill those needs. Furthermore, the physician involved may be more inclined to be forthcoming in such surroundings, without the worry of saying too much and admitting liability. Mediation can create an environment that fosters dialogue between parties outside the legal realm, allowing them to articulate their concerns in a more familiar setting:

> Mediation enables the parties to deal with the issues they believe to be important, as opposed to giving the attorneys cart blanch to argue the legal merits or what they perceive as the most important issues; rather, mediation provides the parties a sense of being heard.

Even where the parties have no interest in preserving their relationship, mediation can serve as an effective means in protecting physicians' reputations and adequately compensating plaintiffs for the harms they have suffered, both physically and emotionally.

In order to clarify the underlying causes of a dispute, mediation makes one of its foremost goals improving communication and understanding between parties. In a doctor-patient relationship, communication is central since without it there is great potential for infringements on personal autonomy. Patients need to be fully informed and consenting to all treatment and procedures. Moreover, communication is often at the centre of doctor-patient disputes. Eric Galton asserts that "every reliable study regarding the etiology of medical malpractice claims points to dysfunctional communication between the healthcare provider and the patient or patient's family as the producing cause of the vast majority of medical negligence lawsuits." In Galton's definition of 'dysfunctional communication', he includes various degrees of faulty explanation as well as the neglect by physicians in effectively

communicating their personal concern and sympathy. Potentially, mediation provides an informal, voluntary and confidential setting "that permits the needs of all parties to be identified, acknowledged, respected, and hopefully met."

Theoretically, the benefits of mediation are widespread. Then again, so are the benefits of tort litigation, theoretically. It is the practicalities of the litigation process that are problematic. Consequently, the implementation of a mediation system for medical malpractice disputes must be carefully structured, anticipating potential difficulties and must also be malleable such that unpredictable problems that are bound to arise can be managed effectively. Gitchell and Plattner promote medical malpractice mediation that prioritizes principles such as "self-determination, signifying that parties must have the ability to voluntarily reach their own agreement, or to end their participation in the mediation and litigate the case." Also, impartiality, fairness and confidentiality are paramount to creating an environment that successfully fosters discussion and mutually satisfactory compromise.

- **Incentives**

In Canada, other important factors to consider in the practicality of implementing mediation include the role of the CMPA. As a non-profit organization, the CMPA stands to benefit from a less costly system, since they potentially could decrease annual membership fees, which make up their reserve fund:

> The Association's funding policy and related fee setting strategy follow a full funded approach. This requires that membership fees be set each year at levels sufficient to allow the financing of all the disbursements (damages and settlements, legal and administrative expenses) which may be estimated actuarially to arise from the professional work carried out by members during the year in question, taking into account that some claims may not commence until long after the year is over and also that many of the disbursements, especially the larger ones, may not be completed until several years later.

The alternative of mediation could potentially cut back costs in damages and especially in legal expenses, which include court costs. Moreover, fewer formalities should diminish the time delay associated with litigation. Assuming physicians are interested in pursuing mediation as an alternative, with its increased use, the CMPA's estimated expenses ought to decrease, allowing for a resulting decrease in membership fees. All this said, the CMPA with a mandate to protect their member physicians will have no incentive to mediate unless the substantive benefits prove more attractive than those of litigation.

Firstly, litigation ought always to remain as a means by which to resolve disputes. Even where parties cannot reach some compromise in a mediation and choose to litigate, "the process of mediation [will have] already clarified many issues, and [will have] created opportunities for the parties to realize arguments which they could present during litigation," making the eventual litigation more focused and expedient. Within mediation, physicians will be provided the opportunity to communicate with the patient or patient's family, perhaps offer some explanation, or apologize - even if the apology is only for the complainant's loss. The assurance of confidentiality in the process should encourage open communication between the parties and a willingness to be forthcoming on the part of the physician. If either party feels their interests will not be adequately addressed in mediation, as long as it remains voluntary, they are free to refuse and to pursue litigation.

Incentives for the patient/complainant include an increased accessibility to resolution. The complainant is provided an opportunity in mediation to clarify any miscommunication, request a

more detailed explanation, and represent their understanding of the events. They also have the opportunity to negotiate an arrangement that involves more flexible remedies than those they have access

to by way of litigating.

- **Implementation**

Successful mediation depends very much on the way in which it is implemented. Detailing an effective program for mediation of medical malpractice disputes may be beyond the scope of this paper, however I think the principles outlined by Gitchell and Plattner - self-determination, impartiality, fairness and confidentiality - present a promising foundation. One option is to set up mediation through the court system, which has been attempted by a few provinces mostly in the area of family law disputes. After initiating litigation, parties to an action would likely meet with a conciliator or case management master who sends them in an appropriate direction, depending on the facts of their case. One direction would be mediation. There are several issues to examine such as whether the mediators would be court-appointed or chosen by the parties; whether the process would be voluntary or mandatory; and whether the procedural difficulties of cost and delay would be effectively addressed. Ideally, the process ought to provide flexibility and informality such that the parties become active participants in the resolution of their dispute, yet structured enough to avoid power imbalances. Much would depend on the choice of mediator.

Another option is to have most complaints go through an administrative board, such as the College, whose Investigation Committee already has the statutory authority to:

a. Dismiss the complaint;
b. Attempt to resolve the matter informally;
c. With the consent of both parties, refer the matter, in whole or in part, for mediation;
d. Refer the matter, in whole or in part, to a hearing committee;
e. Counsel the member or associate member;
f. Caution the member or associate member;
g. Counsel and caution the member or associate member;
h. Reprimand the member or associate member with the member's or associate member's consent; or
i. With the consent of the member or associate member, require the member or associate member to undergo such treatment or re-education as the committee considers necessary.

There are inherent problems with this approach because the College is a self-regulating body and as such may not meet an appropriate standard of impartiality that is necessary in resolving medical malpractice disputes. In addition, though they have the capability to send disputes to mediation, according to the Investigations Coordinator at the College, they rarely do so. Putting the difficulties aside for a moment, if the role of the College could be taken on its face, they might deal with the majority of medical malpractice disputes. In the pilot project, from which I borrowed the idea for the case study, complaints went to a body similar to the College where they were either dealt with by way of disciplinary action in very serious circumstances, dismissed where the concerns were very minor, or referred to voluntary mediation. The outcome of the case I borrowed from was as follows:

> The daughter filed a complaint with the Board of Registration in Medicine stating that the urologist caring for her elderly mother had not properly diagnosed and treated what eventually became cancer of the urinary tract. Over the telephone and without a physical exam, the physician assumed that the reported blood in the patient's urine was an infection, and prescribed antibiotics for the mother. After the bleeding continued, the mother was hospitalized and diagnosed with cancer. At this point her condition was untreatable and she died shortly thereafter. The Board's disciplinary committee investigated and determined that in light of the physician's overall exemplary record,

disciplinary action was not warranted. The dispute was referred for mediation.

The case was assigned to a senior mediator and a mediator trainee (an orthopedic surgeon). The daughter stated that she did not want to sue for damages, as no amount of money could return her mother. Rather, she wanted to be sure that this tragedy not be repeated. The daughter vented her feelings to the physician, and he patiently listened. He expressed his own sorrow for the death of a patient he had seen for many years and of whom he was personally fond.

The physician apologized to the daughter and agreed to enroll in a continuing medical education course on urinary cancer. He also agreed to make a contribution to the American Cancer Society in the amount of $1,000.

Conclusion

There are a number of factors which make disputes in the medical malpractice context unique, only one of which is the nature of the doctor-patient relationship. Though tort litigation sets out to accomplish a number of important objectives, including compensation and deterrence, it does so using a well-structured process that is also aimed at efficiency and expediency. The disputes created in the medical malpractice arena may not be adequately resolved by litigation because the interests involved lie outside the scope of the existing system.

Some of the inadequacies of tort litigation that I have explored would be more appropriately addressed through a process involving voluntary mediation as an accessible alternative. In terms of compensation, mediation offers the possibility of providing more suitable remedies to fit the needs of a complainant, one of which is the desire for explanation. Because mediation places parties in an informal setting, which encourages dialogue, where part of the dispute is a matter of ‘dysfunctional communication,’ parties are better able to resolve their differences. Effective communication in the mediation environment may also create a sense of retribution for the complainant because they are better able to explain their concerns or confusion directly to the physician in a controlled setting. The physician in turn, has an opportunity to offer more in the way of information or explanation and without threat of litigation, might feel comfortable expressing any regret or sympathy for the patient or the patient’s family.

Deterrence is another goal tort law aims to achieve. In the area of medical malpractice, mediation has the potential to be an equally or more effective means by which to achieve the type of overall deterrence that is necessary to prevent future error or negligence. General deterrence is an essential aspect in a dispute resolution process if the aim is to create widespread quality improvement in an area like health care. Since mediation allows for a broad spectrum of remedies, they might include things such as the implementation of safety precautions in a physician’s office, or agreement by the physician to participate in some continuing education courses. The flexibility of the mediation process makes it possible to design remedies that are not only compensatory, but prevent future occurrences of malpractice. "Mediation may, in short, offer a process whose traditional attributes are consistent with, rather than antithetical to, the requisites of quality improvement."

Mediation is by no means a flawless solution to the difficulties of tort litigation. It does however have many features that make it an attractive and viable alternative in the complex and unique context of medical malpractice. Moreover, where the existing system of dispute resolution is struggling to meet its stated aims, I think exploring and implementing various options is essential.

Bibliography

1. Adams, Hon. Mr. Justice G. & N. Bussin, "Alternative Dispute Resolution and Canadian Courts: A Time for Change" (1995) 17 *Advocate's Quarterly* 133.
2. *Athey* v. *Leonati*, [1996] 3 S.C.R. 458.
3. Berryman, J.B., T.A. Cromwell, S. Sadinsky, J.L. Cassels, D.J. Mullan & S.M. Waddams, *Remedies: Cases and Materials*, 3rd ed. (Toronto: Edmond Montgomery Publications Ltd., 1997).
4. Bogart, W.A., *Courts and Country: The Limits of Litigation and the Social and Political Life of Canada* (Toronto: Oxford University Press, 1994).
5. Boulle, L. & K.J. Kelly, *Mediation: Principles, Process, Practice*, Canadian ed. (Toronto: Butterworths, 1998).
6. Brennan, T.A., L.L. Leape, N.M. Laird, L. Hebert, R. Localio, A.G. Lawthers, J.P. Newhouse, P.C. Weiler & H.H. Hiatt, "Special Articles: Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study" (1991) 324 (No. 6) *The New England Journal of Medicine* 370.
7. Buckner, F., "A Physician's Perspective on Mediation Arbitration Clauses in Physician-Patient Contracts" (2000) 28 *Capital University Law Review* 307.
8. *CMPA Annual Report* (1999).
9. Coughlan, S.G., "The 'Adversary System': Rhetoric or Reality?" (1993) 8 *CJLS/RCDS* 139.
10. Dauer, E.A. & L.J. Marcus, "Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement" (1997) 60 *Law & Contemporary Problems* 185.
11. Dauer, E.A., "When Law Gets in the Way: The Dissonant Link of Deterrence and Compensation in the Law of Medical Malpractice" (2000) 28 No.2 *Capital University Law Review* 293.
12. Dauer, E.A., L.J. Marcus & S.M.C. Payne, "Prometheus and the Litigators: A Mediation Odyssey" (June 2000) 21 *Journal of Legal Medicine* 159.
13. Dewees, D. & M. Trebilcock, "The Efficacy of the Tort System and Its Alternatives: A Review of Empirical Evidence" (1992) 30 (No. 1) *Osgoode Hall Law Journal* 57.
14. Dewees, D., D. Duff & M. Trebilcock, *Exploring the Domain of Accident Law: Taking the Facts Seriously*, (New York: Oxford University Press, 1996).
15. Dewees, D.N., M.J. Trebilcock & P.C. Coyte, "The Medical Malpractice Crisis: A Comparative Empirical Perspective" (1991) 54 (No. 1) *Law & Contemporary Problems* 217.
16. Dickens, B.M., "Picard Lecture in Health Law - 1991 Implications of Health Professionals' Legal Liability" (1993) 1 *Health L. J.* 1.
17. *Dorland's Pocket Medical Dictionary*, 25th ed. (Toronto: W.B. Saunders Company, 1995).
18. Elgie, R.G., T.A. Caulfield & M.I. Christie, "Medical Injuries and Malpractice: Is it Time for "No Fault"?" (1993) 1 *Health Law Journal* 97.
19. Emson, H.E., *The Doctor and The Law: A Practical Guide for the Canadian Physician* (Toronto: Butterworths, 1989).
20. Felstiner, W.L.F., R.L. Abel & A. Sarat, "The Emergence and Transformation of Disputes: Naming, Blaming, Claiming…" (19??) 15 *Law & Society Review* 631.
21. Galton, E., "Mediation of Medical Negligence Claims" (2000) 28 No. 2 *Capital University Law Review* 321.
22. Giesen, D. "Vindicating the Patient's Rights: A Comparative Perspective" (1993) 9 *Journal of Contemporary Health Law & Policy* 273.
23. Gilbert, S.M., *Wrongful Death: A Medical Tragedy* (New York: W.W. Norton & Company, 1995).
24. Gitchell, R.L. & A. Plattner, "Mediation: A Viable Alternative to Litigation for Medical Malpractice Cases" (Spring 1999) 2 (No. 3) *DePaul Journal of Health Care Law* 421.
25. Hensler, D.R., "The Real World of Tort Litigation" in A. Sarat, M. Constable, D.Engel, V. Hans & S. Lawrence, eds., *Everyday Practices and Trouble Cases* (Evanston: Northwestern University

Press, 1998) 155.
26. http://www.cmpa.org/english/advice-e.cfm
27. http://www.cmpa.org/english/whatis-e.cfm
28. http://www.cpsns.ns.ca
29. http://www.ichelp.org/WhatIsIC/AnIntroductionToIC.html
30. Johnson, K.B., C.G. Phillips, D. Orentlicher & M.S. Hatlie, "A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims" (1989) 42 *Vanderbilt Law Review* 1365.
31. Leape, L.L., MD, "Error In Medicine" (1994) 272 No. 23 *J.A.M.A.* 1851.
32. Limbert, J., M.D., "Medical Malpractice Litigation Canadian Perspective: The Role of the Medical Expert" (1998) http://www.medlit.net/guests/guidelines/def/meddef.htm.
33. Linden, A.M., *Canadian Tort Law*, 6th ed. (Toronto: Butterworths, 1997).
34. Marshall, P., "Would ADR Have Saved Romeo and Juliet?" (1998) No. 4 36 *Osgoode Hall L. J.* 771.
35. Menkel-Meadow, C., "The Trouble With the Adversary System in a Post-Modern, Multi-Cultural World" (1996) 38 *Wm. & Mary L. Rev.* 5.
36. Metzloff, T.B., "Alternative Dispute Resolution Strategies in Medical Malpractice" (1992) 9 *Alaska Law Review* 429.
37. Metzloff, T.B., R.A. Peeples & C.T. Harris, "Empirical Perspectives on Mediation and Malpractice" (Winter 1997) 60 *Law & Contemporary Problems* 107.
38. Mitchell, C.N. & S. McDiarmid, "Medical Malpractice: A Challenge to Alternative Dispute Resolution" (1988) 3 *CJLS/RCDS* 227.
39. Olson, W.K., *The Litigation Explosion: What Happened When America Unleashed the Lawsuit*, (New York: Truman Talley Books/Dutton, 1991).
40. Osborne, P.H., *The Law of Torts*, (Toronto: Irwin Law, 2000).
41. Prichard, J.R.S., *Liability and Compensation in Health Care* (A Report to the Conference of Deputy Ministers of Health of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care) (Toronto: University of Toronto Press, 1990).
42. Robertson, G.B., "The Efficacy of the Medical Malpractice System: A Canadian Perspective" (1994) *3 Annals of Health Law* 167.
43. *Snell* v. *Farrell* 72 D.L.R. (4th) 289.
44. t*er Neuzen* v. *Korn*, [1995] 3 S.C.R. 674.
45. The Report of the Harvard Medical Practice Study to the State of New York, *Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation and Patient Compensation in New York* (President and Fellows of Harvard College, 1990).
46. Wachsman, H.F., M.D., J.D., *Lethal Medicine: The Epidemic of Medical Malpractice in America* (New York: Henry Hold and Company, Inc., 1993).
47. Weiler, P.C., *Medical Malpractice on Trial*, (Cambridge: Harvard University Press, 1991).