Alternatives to the Court Process for Resolving Medical Malpractice Claims

Introduction

With cases of medical malpractice sharply on the increase in Canada, there is growing apprehension among physicians. Potential plaintiffs remain concerned over the great financial risk involved in suing a physician. Many doctors feel uncomfortable with the courtroom and its method of discovering truth through cross-examination. After some exposure to the courtroom, either as expert witnesses or as defendants in malpractice claims, many physicians come to regard it as an alien environment.[1]

Physicians also regard the potential law-suit as a barrier in the trust relationship that is so often essential to establish a favourable chance of recovery.[2] They perceive that medical realities are quickly reduced to the rhetorical battles of legal experts and that the expert witness is degraded and subjected to a physical and mental ordeal. If the process is protracted, the doctor regards the commitment of energy and time as a distraction from the primary responsibilities of his profession. For the medical man, the courtroom is as intimidating as the operating room to the lawyer. Ultimately, the adversarial method of administering justice may be the single most important deterrent to cooperation between law and medicine.[3]

From the lawyer's standpoint, based on an education in the art of advocacy, the law-suit is not, and cannot be made, a scientific investigation for the discovery of truth.[4] On the other hand, the adversarial approach is a foreign concept in the training and work of physicians, which reflect a cooperative, inquisitorial approach. This tension between the outlooks of the two professions serves on the one hand to fuel the aggressiveness of counsel and on the other brings a response of suspicion and mistrust from the healing

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[1] See Polsky, *The Malpractice Dilemma: A Cure for Frustration* (1957) 30 Temple L. Q. 359, 362.

[2] See Stetler, *Medical-Legal Relations — The Brighter Side* (1957) 2 Villanova L. Rev. 387, 390.

[3] See Child, "Lawyers, Doctors and Medical Malpractice: A Surgeon Reacts" in Institute of Continuing Legal Education, *Medical Malpractice*, 2nd ed. (1966), 43, 47.

[4] See Polsky, *supra*, note 1.

professions. As a result, plaintiffs in medical malpractice suits often find it difficult to obtain a willing medical expert to testify on their behalf.[5]

This comment will explore an alternative to the court as a forum for resolving disputes arising out of the adverse results of medical treatment, as well as an alternative to the necessity of fault-finding as a prerequisite for the compensation of persons suffering such adverse consequences.

I. Compulsory arbitration

One alternative to the court process involves the utilization of a different mode of adjudication,[6] a special forum for dispute resolution with an element of expertise[7] and the authority to make the final decision save for an appeal on limited grounds, such as jurisdiction. Arbitration is the chief alternative adjudicative procedure that has been suggested.[8] The perceived advantages[9] provided by arbitration are many. First, the setting is removed from the formality of the courtroom[10] to a more relaxed environment. One Michigan surgeon suggests that:

> the needs seem clear to me — to devise new settings, new instruments and new proceedings whereby the wrongs of medicine, real or imagined, can promptly be converted to reasonable dollars. Surely a better way

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[5] See Louisell & Williams, *Trial of Medical Malpractice Cases* (1960); Armstrong, *Medical Malpractice — The "Locality Rule" and the "Conspiracy of Silence"* (1970) 22 S. Carolina L. Rev. 810, 818; Markus, *Conspiracy of Silence* (1965) 14 Cleveland-Marshall L. Rev. 520, 523; Kelner, *The Silent Doctor — The Conspiracy of Silence* (1970) 5 U. Richmond L. Rev. 119; Belli, *An Ancient Therapy Still Applied: The Silent Medical Treatment* (1956) 1 Villanova L. Rev. 250, 251, 254; Smookler, *Doctors' Conspiracy of Silence Often Makes Them Their Own Worst Enemies* The Medical Post (April, 1972), 27.

[6] See King, *Malpractice Prevention: A Bi-professional Approach* (1971) 582 Ins. L.J. 335, 338.

[7] See *Wetherall* v. *Harrison* [1976] Q.B. 773.

[8] *Black's Law Dictionary*, 5th ed. (1979) defines arbitration as "[t]he referenee of a dispute to an impartial (third) person chosen by the parties to the dispute who agree in advance to abide by the arbitrator's award issued after a hearing at which both parties have an opportunity to be heard." An arbitration clause is defined as "a clause inserted in a contract providing for compulsory arbitration in case of dispute as to rights or liabilities under such contract."

[9] See generally Bergen, *Arbitration of Medical Liability* (1970) 211 J.A.M.A. 175, 176; Adams, *Grievance Arbitration and Judicial Review in North America* (1971) 9 Osgoode Hall L.J. 443, 448.

[10] Marshall, *Medical Evidence in Malpractice Actions* (1970) 18 Chitty's L.J. 6, 7.

> than is now apparent can be devised which will divorce the whole of malpractice actions from clashing personalities, throbbing emotions, and failures in communication. Certainly surroundings and roles can be made available in which doctors, lawyers, and clients are at ease and effective, naturally as well as by training and by practice.[11]

In addition, and aside from the obvious savings in time and expense,[12] is the fact that the arbitrator on whom the parties must agree and to whom specific questions can be submitted for decision, will usually possess a sophisticated degree of expertise.[13] The greater informality and speed provided through arbitration and the confidentiality of the proceedings are major advantages over the formal, publicity-ridden[14] adjudication of disputes in the courts.

An examination of existing schemes[15] may well prove instructive. All subscribers to one health care plan in Los Angeles[16] sign a contract containing the following clause:

> In the event of any controversy between the subscribing group and the subscriber or dependent, or the heirs at law or personal representative of the subscriber or dependent, as the case may be, and Ross-Loos, when involving a claim in tort, contract or otherwise, the same shall be settled by arbitration.

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[11] Child, *supra*, note 3, 53.

[12] See Santoorgian, *Arbitration of Third Party Liability Claims: One Company's Experiment* (1969) 24 Arbitration J. 161, 163. Indeed, a primary concern among insurers, the uncertainty of leaving the *quantum* issue to a jury, could be dealt with through agreement by the parties to limit the size of awards, with such restriction to be included in the arbitrator's terms of reference.

[13] See Bergen, *supra*, note 9, 176.

[14] Secrecy, and the resultant benefit to the physician-defendant's reputation, is often cited as one major advantage to arbitration. However, even if arbitrations are held behind closed doors, if the practice becomes widespread or compulsory, the pressure to publish reports will be irresistible both as a guarantee of fairness and to promote uniformity in awards.

[15] Most common law jurisdictions provide a mechanism whereby parties to an existing dispute can agree to submit it to arbitration and enforce the decision of the arbitrator. See *An Analysis of State Legislative Responses to the Medical Malpractice Crisis* [1975] Duke L.J. 1417, 1464, n. 235. *The Arbitrations Act*, R.S.O. 1970, c. 25 (as am.) provides that a written agreement to submit present or future differences to arbitration, unless a contrary intention is expressed, is irrevocable, except by leave of the court, and has the same effect as if it had been made an order of the court, and where an appeal is provided for it is to a judge in court and from him to the Court of Appeal. Thus, in Ontario, parties about to enter a contract, such as a patient and physician or hospital, can agree to arbitrate any dispute that may in the future arise out of such contract. For a Pennsylvania plan requiring arbitration of personal injury claims under $3,000.00, see Bergen, *supra*, note 9, 175, 176.

[16] Referred to in Lillard, *Arbitration of Medical Malpractice Claims* (1971) 26 Arbitration J. 193, 197, 198.

The validity of this clause was tested in a case[17] where the child of a subscriber to the plan was injured allegedly as the result of malpractice. The Court held that the clause was a reasonable restriction on the forum for settling disputes and that a father could contract for medical care which would bind his children to arbitration of any dispute arising under the scheme.

Standard practice in several California hospitals is to include in their admission form to be signed by all new patients the following clause:

> *Arbitration Option:* Any legal claim or civil action in connection with this hospitalization, by or against hospital or its employees or any doctor of medicine agreeing in writing to be bound by this provision, shall be settled by arbitration at the option of any party bound by this provision, in accordance with the Commercial Arbitration Rules of the American Arbitration Association and with the Hospital Arbitration Regulations of the California Hospital Association (copies available on request at the hospital admission office), unless patient or undersigned initials below or sends a written communication to the contrary to the hospital within thirty (30) days of the date of patient discharge.
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> If patient, or undersigned, does not agree to the "Arbitration Option", then he will initial here._____[18]

As of 1971,[19] 100,000 patients had agreed to this arbitration option while only a handful rejected it. The procedure requires each party to pay a fee to the American Arbitration Association when a dispute arises. In claims under $20,000,[20] one arbitrator (a lawyer) is appointed, while in larger ones, there are three (a physician, lawyer and businessman).

Two difficulties immediately come to mind with respect to such agreements. First, the voluntariness of the patient's agreement may be suspect, particularly where hospitals require patients to sign as a condition of admission.[21] Also, the physical and mental condition of the patient may in itself raise doubts as to the patient's capacity to agree to anything. Second is the onus imposed on physicians and hospital employees to carefully explain the ramifications

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[17] *Doyle* v. *Guiliucci* 401 P. 2d 1 (Cal. *in banco* 1965).

[18] Referred to in Bergen, *Medical Arbitration Experiments* (1970) 211 J.A.M.A. 351, 352.

[19] See Lillard, *supra*, note 16, 198.

[20] See Bergen, *supra*, note 18, 352.

[21] While most such contracts give the patient the ability to rescind the agreement, the period provided is usually quite brief and the patient is required to take positive action to do so in circumstances when he is still dependent on the good-will of the physician. See *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, *supra*, note 15, 1466, n. 252.

of such an agreement to the patients, including the fact that they are relinquishing their rights to a trial.[22]

A model arbitration agreement has been proposed[23] which involves reducing the implied physician-patient contract to writing. The contract contains a provision for arbitration of future disputes arising from the treatment in consideration of the physician's agreement to undertake the treatment and provide his services.[24]

Ontario physicians or hospitals could conceivably adopt such a procedure providing for arbitration, and for agreement on the selection and qualifications of the arbitrators. The provisions of *The Arbitrations Act*[25] would then apply and any court intervention in the malpractice dispute would be limited to review by way of appeal.[26]

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[22] This is of particular importance in the United States where there exists a state-guaranteed right to a jury trial: see *ibid.*, 1466, n. 252.

[23] Lillard, *supra*, note 16, 212, n. 40. Lillard's model includes the following provision:

> In consideration of the above named Physician's agreement to undertake the treatment of the undersigned Patient, and in further consideration of the substantial professional services to be rendered to said Patient by said Physician, and in full acknowledgment of the dangers to said Patient which may be inherent in or result from said treatment, the undersigned Patient, the undersigned spouse of Patient, and the undersigned Physician hereby respectively convenant and agree that each and every case, controversy, claim, declaration, suit, complaint, action or otherwise, whether in contract or in tort, which may hereafter arise for any reason or from any cause or source between or among any or all of said parties, their respective assigns, heirs, and/or legal representatives, shall be settled only in accordance with the Rules of the American Arbitration Association as hereinafter modified and judgment upon the award rendered by the Arbitrators shall be entered in a Court of Record having jurisdiction thereof. The parties hereto further acknowledge their understanding and/or agreement:
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> 1. That arbitration can provide a speedier, more efficient and more economical method of determining disputes or controversies between them than the normal determination by a Court or Jury.
> 2. That these parties have specifically been afforded an opportunity to discuss this Agreement with their respective attorneys before its execution.
> 3. That each party to an arbitration initiated hereunder shall have the right to use any discovery procedure which would have been available in a civil action pursuant to the (State) Court Rules and the Arbitrator(s) shall regulate such discovery.

[24] This undoubtedly represents consideration in addition to his usual fee.

[25] R.S.O. 1970, c. 25, ss. 4, 7, 9, 13, 14, 16 & 26.

[26] Where no provision allowing an appeal appears in the agreement, a court may still interfere if and when any error of law appears on the face of the decision by the arbitrator: see *Faubert & Watts* v. *Temagami Mining*

While it is arguable that arbitration might not resolve the patient's difficulties in obtaining expert evidence, the informal setting and the medical qualifications of one of the arbitrators may ease this burden. The expense-saving factor would serve as a major impetus to plaintiffs, but this course would also be attractive to physician-defendants because of the private forum and to their insurers where agreed-on limitations in the size of awards are incorporated in the questions put to the arbitrators. All in all, arbitration appears to provide a viable option to the court process as a dispute resolution mechanism for handling malpractice claims.

II. No-fault medical malpractice insurance

Certain courts have demonstrated a propensity to abandon the negligence rule of liability in favour of a theory of strict liability[27] for certain types of adverse results of medical treatment. While some rigorously oppose such a position,[28] in recent years, buoyed by the successful application of no-fault principles to the car accident arena, suggestions have poured forth[29] holding out this innovation as a panacea for the medical accident scene. Typical are the remarks of Carlson:

> A no-fault system strips away the interrogative aspects of malpractice and focuses instead upon the nature and extent of a patient's prognosis.

Co. Ltd. [1960] S.C.R. 235. If arbitration were to be imposed on the parties legislatively as a complete substitute for the court process (see *An Analysis of State Legislative Responses, supra*, note 15, 1465, n. 246), either party could bring a motion for judicial review pursuant to *The Judicial Review Procedure Act, 1971*, S.O. 1971, c. 48 (as. am.).

[27] A position suggested by several writers. See Miller, *Cases of Uncertain or Unknown Causation and Negligence: Relationship Analysis as a Real Alternative to Present Inadequate Concepts* [1968] U. Kansas L. Rev. 209, 235; Tunc, *A Little-Noticed Theory in the Law of Tort: Boris Starck's Theory of Guaranty* (1973) 121 U. Pa L. Rev. 618, 621; Keeton, *Compensation for Medical Accidents* (1973) 121 U. Pa L. Rev. 590, 607, n. 48; Note, *The California Malpractice Controversy* (1956-57) 9 Stan. L. Rev. 731, 742.

[28] See, *e.g.*, Gibbons, *Malpractice Actions without Expert Medical Testimony* (1971) 20 Cleveland State L. Rev. 43, 52.

[29] See, *e.g.*, Belli, as noted in Adamson, *Medical Malpractice: Misuse of Res Ipsa Loquitur* (1962) 46 Minn. L. Rev. 1043, 1055, n. 35; Louisell, "Lawyers, Doctors and Medical Malpractice: A Legal Viewpoint" in Institute for Continuing Legal Education, *supra*, note 3, 59, 65-6. For similar suggestions restricted to hospitals, see Marshall, *supra*, note 10, 11; Ehrenzweig, *Compulsory "Hospital Accident" Insurance: A Needed First Step Toward the Displacement of Liability for "Medical Malpractice"* (1964) 31 U. Chi. L. Rev. 279, 284, 285, 288, 289; O'Connell, *No-fault Insurance for Injuries arising from Medical Treatment: A Proposal for Elective Coverage* (1975) 24 Emory L.J. 21.

> The physician is no longer made the subject of an extensive examination in order to determine whether any recompense will be made... Expert testimony relating to the mal- or misfeasance of a fellow professional is not required; neither is penetrating examination and cross-examination of the defendant. Since 'fault' need not be predicated, pursuit of the etiology of an injury is irrelevant. It follows then that providers may be more willing to participate in furnishing information upon which to base compensability decisions in an atmosphere free from fault-finding.[30]

There are a number of factors to be considered before removing medical accidents from the tort law arena. The existing scheme, in theory anyway, permits an individual to confront a physician in an open forum with objective judges who will examine his actions in the light of generally prevailing values of the community. From a physician's viewpoint, he will be asked to account for his actions only where alleged negligence is actually proven. If a no-fault scheme is adopted, control over physicians' performance will be left to the organized profession with the possibility that such immunity may encourage the development of a feeling of indifference to medical accidents on the part of doctors.[31]

On the other hand, many drawbacks to the present system have been enumerated.[32] These include the randomness of the rewards of the present system with some gaining high recoveries but most others sustaining injuries which go uncompensated because they either lose their action, fail to pursue their claims, or, through ignorance or fear of the financial risks, never initiate an action; the inordinate delay in compensation with most plaintiffs waiting years after the injury for a final determination of their claim by the courts; practicing in a "defensive" manner by cautious physicians afraid of a potential suit and the deleterious effect of such conservatism on innovation, the adoption of new medical techniques, and medical practice and professional services generally; and finally, the costs involved.[33]

Few of the objectives of a good compensation scheme enumerated by Keeton[34] are met by the existing tort mechanism for dealing

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[30] *A Conceptualization of a No-fault Compensation for Medical Injuries* (1973) 7 Law & Soc'y Rev. 329, 362.

[31] See Kretzmer, *Aims and Functions of the Tort System of Loss Allocation*, unpublished LL.M. thesis, Osgoode Hall Law School (1974), 378. See also note 28, *supra.*

[32] See Carlson, *supra*, note 30, 332-40. A summary of physicians' grievances may be found in *Medical Malpractice Litigation: Some Suggested Improvements and a Possible Alternative* (1966) 18 U. Fla L. Rev. 623, 625.

[33] See Carlson, *supra*, note 30, 335-6.

[34] *Supra*, note 27, 603:

> First, a good system of compensation will be equitable, and it will be so from each of three different perspectives — between those who

with medical accidents. Keeton argues that such a scheme ought to provide at least a subsistence level of compensation for all victims, much in the manner of workmen's compensation schemes and no-fault car plans, rather than restricting compensation to cases of proven negligence or fault.

Of particular concern in Canada is the tendency of insurers not to settle malpractice claims as well as the crushing expenses[35] of pursuing such a claim with the result that little or no compensation is available for those suffering minor or moderate injuries. Once in court, a plaintiff has the double burden of first establishing causation and then the blameworthy character of such causation.[36] Another major drawback is the defensive response of the medical profession to the increasing number of suits as seen in a growing conservatism among practicing physicians reluctant to undertake innovative or high-risk procedures and a tendency to "over-test" their patients at great expense as a precautionary measure against the threat of a suit.[37]

Also, the utilization of tort law as a mechanism for exerting social control over the medical profession and forcing accountability of negligent physicians can be described as a myth,[38] particularly in

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receive its benefits and those who bear the burden of its costs, among different beneficiaries, and among different cost-bearers.

Second, the system will contribute to the protection, enhancement, and wise allocation of society's human and economic resources.

Third, the system will compensate promptly. It will meet economic burdens as they occur, and it will provide for medical and other rehabilitative services as they are needed.

Fourth, the system will be reliable. It will give assurance of financial responsibility for the payment of compensation determined to be due, and the determinations of entitlement to benefits and responsibility for costs will be predictable.

Fifth, the system will distribute losses rather than impose or leave crushing burdens on individuals.

Sixth, the system will be efficient, minimizing waste and overhead.

Seventh, the system will avoid inducements and, if feasible, provide affirmative deterrents to antisocial risk conduct.

Eighth, the system will minimize inducements to exaggeration and fraud and opportunities for profit from such conduct. This is essential to the integrity and equity of the system and to cost control as well.

[35] Kretzmer, *supra*, note 31, 410, states that: "[e]ven if a plaintiff who honestly believes that he has a well-based claim against a doctor is prepared to weather the storm and pursue his claim, he takes a considerable risk, for if he loses the case he is invariably faced with a huge bill which is out of all proportion to the amount he stood to gain."

[36] See Ehrenzweig, *supra*, note 29.

[37] See Carlson, *supra*, note 30, 334, 338.

[38] See Kretzmer, *supra*, note 31, 377; Carlson, *supra*, note 30, 353.

Canada, because of the near impossibility of pursuing a claim. The inordinate delay in obtaining compensation through the courts is a feature of which all trial lawyers are well aware.

Those proposing adoption of a no-fault scheme rely on the successful precedent of its substitution for the tort liability mechanism in the case of automobile accidents.[39] No-fault schemes for car crashes are presently in existence in several jurisdictions, including Ontario,[40] whereby all victims are compensated, to a limited degree, without regard to fault and without eliminating their right to pursue the wrongdoer through the courts.[41] A comparison of medical accidents and road accidents might thus prove instructive.

Robert Keeton, one of the original exponents of the application of no-fault principles to car accidents,[42] sets out his view of the underlying principles of a no-fault system, as

> first, the principle of paying benefits without regard to fault; second, the principle of paying these benefits through private-enterprise insurers; and third, using these nonfault, private-enterprise payments as the principal source of compensation for victims who sustain injuries within the scope of the insurance contracts. A very significant corollary of the third principle is that there be a partial or total exemption from liability based on negligence.[43]

Contrasting the systems for medical and traffic victims reveals several interesting factors.[44] First, malpractice victims who suffer minor injuries receive little or no compensation,[45] because of the insurer's propensity not to settle, the financial implications of pursuing a losing action, and the small award likely to result even if successful. Also, severe injuries receive large awards, particularly in the United States. The opposite is usually the case with road accident victims. Car crash plaintiffs do not confront the problem of obtaining medical experts. Experts are not usually required on

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[39] See O'Connell, *Expanding No-fault beyond Insurance: Some Proposals* (1973) 59 Va L. Rev. 749; Tunc, *Tort Law and Moral Law* [1972] C.L.J. 274, 258; Kroll, *The Etiology, Pulse and Prognosis of Medical Malpractice* (1974) 8 Suffolk L. Rev. 598.

[40] See *The Insurance Amendment Act, 1971*, S.O. 1971, c. 84 (as am.) ss. 14, 15.

[41] See Linden, *Canadian Negligence Law* (1972), 457.

[42] See Keeton & O'Connell, *Basic Protection of the Traffic Victim: A Blueprint for Reforming Automobile Insurance* (1965).

[43] Keeton, *supra*, note 27, 601.

[44] *Ibid.*, 594-6, 599: see also Carlson, *supra*, note 30, 356, 364; Kretzmer, *supra*, note 31, 345, 346. One obvious distinction is the fact that motorists are both potential plaintiffs and defendants, while patients always fall into the former category.

[45] See Keeton, *supra*, note 27, 616.

the negligence issue and medical reports ordinarily suffice to establish the extent of the injuries. The deterrence feature also presents qualitative differences. Presumably, fear of injury provides sufficient incentive for drivers to conduct themselves in a careful manner. With the possible exception of psychiatric treatment with certain categories of dangerous psychotics, this factor is not relevant in the treatment sphere. Moreover, a motorist accused of negligence does not face the same professional sanctions and embarrassment as does a physician-defendant in a malpractice suit.

The most fundamental difference lies in the area of causation. Traffic injuries rarely raise difficult causation issues, but they tend to be the order of the day in malpractice actions. Indeed, sorting out the cause problem might well prove as difficult and expensive as sorting out the fault problem. A fundamental aspect of the causation issue is the determination of whether the victim's present condition is a result of the malpractice or a natural deterioration in his illness. While pre-existing disabilities are sometimes factors to be reckoned with in automobile claims, they are ever-present features of medical treatment. Carlson explains that:

> Conceptualization of a no-fault system for automobile accident compensation is relatively simple. The determinant of recovery, once fault-finding is removed, is merely whether or not the injury was caused by an accident which is covered by the system. A car crash is a car crash is a car crash. But, the task of isolating a determinant of recovery for medical injury compensation is far more complex...[46]

Unless we envisage some form of social security[47] with a criterion for compensation which ignores the causal connection between the plaintiff's condition and the medical treatment received (which would no doubt be prohibitively expensive), the causation issue remains a major obstacle to the development of a viable no-fault scheme for medical accidents.

A better analogy has often been drawn between medical accidents and industrial mishaps. Before workmen's compensation,[48] which was the first comprehensive no-fault scheme designed to replace the common law, few victims of industrial accidents ever received compensation.[49] Now, a victim recovers so long as he is an employee when injured.[50] Carlson argues that if such a compensation

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[46] *Supra*, note 30, 356.

[47] See Keeton, *supra*, note 27, 597, 601, 604. Such a plan substantially exists for medical expenses in the province of Ontario: see *The Health Insurance Act, 1972*, S.O. 1972, c. 91 (as am.).

[48] See *The Workmen's Compensation Act*, R.S.O. 1970, c. 505 (as am.).

[49] See Keeton, *supra*, note 27, 592; Carlson, *supra*, note 30, 355, 356; Kretzmer, *supra*, note 31, 418, 419.

[50] R.S.O. 1970, c. 505, s. 3(1).

scheme were adopted for medical accidents, a determination of standing to bring a claim would be easier here because:

> A patient's contacts with the health care system are much more discrete than a worker's contact with work where all kinds of putatively compensable events can occur. For example, in the employment context questions as to an employee's relationship to his employment arise at all the edges of his normal work tasks — on the way to work, on the way home, at the company picnic and so on. In the health care system, since the number of causative agents are vastly fewer and because the patient enters and leaves the health care system and the provider's ministrations at very definable points, the number of cases in dispute should be proportionately far fewer. After all, an employee can be injured in any number of ways and recover as long as he is an employee when injured. A patient, it is true, must be a patient (an event of much less duration and breadth) but must also be injured only by agents of the health care system. Thus, by reverse analogy, if the test for compensation for medical injury were transposed to the employment context, only injuries sustained by employees caused by contact with the employer or his agents would be actionable — not injuries from other sources like fellow employees, streetcars, parking lot attendants, baseball bats, and defective machinery.[51]

Although some experts have discouraged[52] a move to no-fault principles for medical accidents, others have taken pains to devise model schemes.[53] Carlson suggests that compensation scales be developed which focus:

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[51] *Supra,* note 30, 355. His suggestion would not appear to resolve the principal causation problem, *i.e.,* distinguishing injuries due to pre-existing conditions from "in-treatment" injuries.

[52] *E.g.,* Keeton, *supra,* note 27, 616. At the Second Annual Law/Medicine Seminar in Detroit, Keeton, in a presentation entitled *Are No-fault Concepts Transferable to Medical Accidents?,* felt that one of the major obstacles involves defining the recipient. He pointed out that it is relatively simple to say that anyone injured as a result of an automobile accident will be compensated, but how does one define the "victim of a medical accident". Does everyone who leaves a hospital or a doctor's office worse off than when they entered receive compensation? What happens to the age-old rule that permits risk-taking in surgery when the patient is aware that, say, a 5 *per cent* chance exists that he will be worse off than before? Is every poor surgical result to be compensable?

[53] Kretzmer, *supra,* note 31, 415, 416, suggests the development of a two-stage procedure. First, a determination would be made as to whether the plaintiff had suffered an untoward result and what compensation was due to him. Second, an attempt would be made to investigate the cause of the adverse result which would be used to analyze the risks of various types of treatment and to implement quality control among individual physicians. See generally *Congress Takes a Look at a No-fault Proposal for Medical Malpractice: Some Observations* (1975) 9 Akron L. Rev. 116; Waxman, *Assembly Select Committee on Medical Malpractice: Preliminary Report* (California State Assembly, 1974), 59.

> on the end results of care, judging quality on the basis of the patient's condition after an episode of care has concluded (*e.g.*, dead, deteriorated, improved, recovered, *etc.*), compared to expected outcome rates for similar age groups, disease, *etc.*[54]

Presumably, if medical technology is sufficiently sophisticated so as to be capable of developing a table of "expected outcomes" given the variables of age, physical condition before treatment, risks inherent in treatment (although compensation may be extended to include victims of untoward results which are manifestations of anticipated risks, available treatments, and so on), and if the causation issue[55] is resolved, such a proposal could represent a viable alternative to the necessity of fault-finding as a prerequisite to the compensation of persons suffering from the adverse consequences of medical treatment.[56]

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[54] *Supra*, note 30, 358, 359, 360. He structures his scheme as follows:

1. A no-fault system to determine compensation (ignores) the methodology of care and focuses exclusively on the 'outcomes' of care.
2. To the extent possible, a determination of compensability should be based upon an objective means of evaluating a patient's 'outcome' against scales or measures of results for the procedure or procedures in question.
3. Compensation (under a no-fault system) therefore is not paid for all disability states resulting from the provisions of health care services (theoretically many health care results leave the patient in a more 'disabled state' than before he or she entered the system even if they produce an optimal recovery); rather, compensation is paid for the degree of deviation of a patient's outcome from a range of expected outcomes for like procedures.
4. Finally, while assessments of compensations are made without reference to the behavior of the providers, once compensation issues have been resolved, 'process reviews' of provider behavior (and other 'disciplinary' mechanisms) to correct sub-performance ostensibly contributing to (if not proximately causing) the claim in question can and should be made.

[55] See Keeton, *supra*, note 27, 614, 615.

[56] A compromise scheme derived from Linden's remarks in *Canadian Negligence Law* (*supra*, note 41, 457) would involve offering some immediate compensation to such individuals while retaining their right to bring civil action. (In this manner, fault and no-fault concepts might complement one another in what Linden refers to as "the peaceful co-existence plan".) Thus persons unable to bring medical malpractice actions for a lack of funds or a lack of medical experts will be guaranteed a minimum level of compensation.

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