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A comedy of errors? Tort, contract and compensation schemes as remedies for medical malpractice

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Abstract: The article is aimed at pointing out the differences between the contractual and the tortious approach to medical negligence and how both of them, generally, bring about similar results. At the same time alternative compensation schemes seem to draw criticism and appear to be unsatisfactory in those countries which adopt them. The conclusion is that, perhaps, the legal framework is not so important and does not have such a significant impact on the medical sector as many academic lawyers believe.

Keywords: medical negligence; contract; tort; compensation schemes; comparative law

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1 Introduction

In the last decade Italian medical negligence law has moved from a theoretical and practical equidistance between a tortious and a contractual approach towards an explicitly contractual one, using the typical concepts of a creditor/debtor relationship in order to affirm liability of the physician or of the medical institution.

Previously the area of negligence was, roughly, divided into three hypotheses: when the medical act was of particular difficulty liability was incurred only if gross negligence on behalf of the doctor was proven by the plaintiff; when the medical intervention was routine (typically the extraction of a tooth, minor surgery) liability was presumed on the basis of principles equivalent to res ipsa loquitur, therefore shifting the burden of proof onto the defendant. For cases falling in between it fell to the plaintiff to prove fault, causation and damage. Lacking clear and convincing evidence the claim was rejected on the basis of the brocard actore non probante reus absolvitur.

The present state of the law, however, applies to the defendant physician and medical institution the general principal of contract law for which, once the creditor has claimed non-performance, it falls to the debtor to prove either performance or the existence of intervening factors which have prevented him from correctly performing his obligation, or some external event which has caused the damage. Furthermore, the doctor and the

medical institution are "in the proximity of evidence" and therefore it is appropriate, from a policy point of view, that they should give the evidence discharging them of liability.

It should be pointed out that Italian medical negligence law – as in all other jurisdictions, whether of civil law or of common law – is judge-made law, developed incrementally over the decades through progressive adjustments by the Courts.

It is worth noting, in the latest developments of Italian law, that they are due not to a slow change of case-law by the lower courts which has slowly seeped through the judiciary, but to a rather fast revirement by the Italian supreme civil justice court, the Corte di Cassazione, which has systematically reversed decisions by the various appeal courts which had decided in favour of physicians and medical institutions.

This rapid change of attitude has received mixed comments, and some authors have expressed the fear that it will gradually bring about in Italy a malpractice crisis, similar to that which struck the US in the '70s and the '80s. The cause of this predicament is seen in the shift to an overtly contractual system, while the tort liability system, with its various and widely litigated exceptions, is considered more balanced in the obvious conflict between the competing interests of plaintiff and defendant.

This article intends to examine, from a comparative law perspective, whether the choice of a contractual liability system – rather than a tortious one – is really to be considered the cause of the change in the law and what may be the alternative solutions to the enduring tort/contract conflict.

2 A comparative survey

Very schematically, from a theoretical point of view, comparison appears rather straightforward. While in civil law systems the contractual approach prevails, in common law systems tort is preferred. The distinction however is not in itself decisive: there are "contractual" systems which restrict the plaintiff's chances of success by using the category of "*obligations de moyens*" (*i.e.* a defendant who has taken appropriate care discharges his obligation even if the desired outcome is not achieved); and tort systems that are extremely open to the plaintiff's claim through the principle of *res ipsa loquitur* or other ways of shifting the burden of the proof onto the defendant.

It is therefore necessary to look at how each system works from an operational – rather than theoretical – point of view. It is hardly surprising that the civil law systems look for a model to the common law ones and vice versa. Which is at least evidence of considerable ambiguity in the two models, and of the fact that they can be interpreted in more than one way.

According to the author of the most complete comparative study on medical liability "there is not much difference between the possible consequences for the doctor of the violation of his contractual duties in the medical field, and of his duty of care in the context of non-contractual liability" (GIESEN, 1988, p.9).

Is it really so?

2.1 The US experience

A convenient starting point is an analysis of the American experience, for it was here that an explosion of medical malpractice litigation first occurred. Although it is admitted that between the patient and his doctor there is a contractual relationship (MILLER,

1953; MOCHALSKY, 1985), claims brought by the former against the latter are generally grounded in tort. The reason appears to be quite simple. In tort actions punitive damages can always be asked for and are often granted. In contract actions it is much more difficult and rare to obtain them. The plaintiff's choice of action is therefore inevitable, and quite rational.

Apart from the availability of punitive damages, in itself grounding a claim in tort rather than in contract is not more advantageous for the plaintiff. The reason for the preference is that medical liability has been caught up in the general movement towards the expansion of tort claims. Tort law has become, in a few decades, one of the main factors in the regulation of economic and social activities, governed by the courts. Whether in product liability or environmental protection, financial markets or transport services, judicial activism has taken the place, in the US, of what in Europe is generally regulation by government. While in Europe ex ante regulation is preferred, in the US this is substituted by a very strong system of ex post sanction, consistent with one of the historical tenets of American history: great freedom entails great responsibilities.

This is one of the explanations of why the US courts have extended to medical liability the principle of res ipsa loquitur, forged for the first time in mid 19th century England (Byrne v. Boadle, 159 Eng.Rep. 299 (1863)) using it in a much broader way (SILVER, 1992). The result is that the plaintiff has the burden of proving that he has acted with the appropriate care and that the damage is not attributable to him.

In order to apply the res ipsa principle three elements are generally required: i. The event must be of a kind that normally does not occur in the absence of somebody's negligence; ii. It must have been caused by activities or instruments under the exclusive control of the defendant; iii. The damaged party must not have contributed in producing the event (SILVER, 1992).

Through the enormous amount of case law one can detect an attentive use of the res ipsa principle in medical malpractice cases. In particular it is not applied when the causes of the damage are multiple; or when the risk for the patient has been created in order to avoid a greater risk. It is considered as a simple presumption of negligence that does not bind the jury and can be overturned by other evidence.

From the point of view of causation, the general tendency by State courts is towards the "but for test" (which in civil law jurisdictions is equivalent to the condicio sine qua non. However over the last decades, as a reaction to the uncertainties of the "but for" test some courts, especially in California, have adopted a "substantial factor test", which, in Europe, would be called "adequate causation" (DOBBS, 2000).

One should also point out, from a comparative point of view, one of the distinctive features of tort litigation in the US (including medical malpractice). Evidence on the technical aspects of the medical case, adherence to (or departure from) professional standards, causal influence of the defendant's actions or omissions is given by the expert witnesses of the parties and following adversarial procedures. They must give the jury "clear and convincing evidence" on these aspects, because the issue of negligence is an issue of fact and therefore within the domain of the jury (MARDER, 2004; VIDMAR, 1994). One can easily appreciate the differences from civil law systems in which such elements are provided by a court-appointed expert who refers to the judge.

Although the principles and procedures applied to medical liability are similar to those of general tort litigation, the US medical sector underwent, especially in the 1970s and '80s, what is commonly called a malpractice crisis with thousands of cases brought against physicians, medical personnel and medical institutions. This resulted in a surge in

damage awards, both in number and amount, the flight of insurance companies from the sector, the theory (and practice) of so-called "defensive medicine". The social effects of such a change were, and still are, seen as unwelcome and unnecessary. In particular it has been pointed out that the system has an effect of over-deterrence with an enormous increase in costs without any substantial benefit for most of the patients. The reply of many States has been that of introducing counter-measures both in substantive law (statutes of limitations, ceilings to damage awards) and in procedural law (ADR, prior examination on admissibility of claim) (DANZON, 1987).

Against this background one should consider the proposal by some well known scholars to apply contractual rules to medical liability. The most important contribution to the debate comes from one of the most prominent "Chicago school" professors, Richard Epstein, who in a seminal article (EPSTEIN, 1976), points out what appear to him the main defects of the tortious approach:

i. Tort rules have a general scope. Once they have been applied to one, they must be applied, on the basis of elementary justice, to all. This does not allow the special relationship which may exist between the parties to be taken into account.

ii. Tort law gives the judge the opportunity (and the temptation) to solve private relations with policy solutions, by which the courts become "social engineers". Tort law becomes a sort of social insurance system with allocation of losses and distribution of risks.

iii. Tort law generally applies when between plaintiff and defendant there is no previous relationship. In the patient-doctor relationship there is, however, a constant interaction between the conditions, the symptoms, the wishes, the expectations, the requests of the former and the conduct of the latter, which is inevitable and indeed a duty.

iv. Strict liability cannot be applied to obligations of prestations – such as those that apply to the physician – because these arise out of consent between the parties. Without such consent one cannot impose upon a doctor a duty to cure a patient.

v. In the doctor/patient relationship risks arise and are borne not in an indiscriminate way, but must be distributed in accordance with the specific qualities of the parties (specialization of the physician, technical instruments available to him, health conditions of the patient).

vi. In a strict liability system a doctor may defend himself by asking for higher remuneration, but this does not offer more guarantees of a safer service. The system therefore is neither rational nor efficient.

vii. Strict liablity transforms a contract for the prestation of services into a guarantee of the result of such services.

viii. There is a clear contradiction between the insistence on informed consent – which implies a rational evaluation of risks, typical of a contractual relationship – and, once the patient's consent is obtained, ignoring it completely when establishing the nature and the extent of the doctor's obligations towards the patient , which are fixed by the courts in an a tortious context.

ix. Finally the practical application of the *res ipsa* principle requires the court to establish that the damage does not usually happen in the

absence of negligence. Here the concept of normality is subjective and devoid of a scientific basis.

Epstein's views – which have been developed in further writings (EPSTEIN, 1997, and previously EPSTEIN, 1988) – have received a thorough critique by another important tort lawyer, Gary Schwartz, from UCLA (SCHWARTZ, 1998). In brief these are Schwartz's arguments:

i. Case law on medical negligence has remained substantially stable since the mid 19th century and has been grounded in tort law and not in contract.

ii. The various attempts by the medical profession – but also by other professions – to limit their liability via contract theory have always met with the opposition of the courts on the grounds of public policy, due to their particular societal role and the trust that they receive and must inspire.

iii. Undoubtedly there has been an expansion of the *res ipsa* principle, but not such as to overturn it.

iv. Statistics indicate that there has been a growing amount of medical negligence litigation, but do not indicate that the percentage of success by plaintiffs has increased. It remains around one third, surely far inferior to that of other sectors.

v. The medical litigation crisis is due to an increase in litigation, in accordance with a general trend in the US, and to an increase in damages awarded, again in accordance with general US trends.

vi. Once one applies contractual rules to doctor/patient relations it is reasonable to expect that the former would ask for (and be able to obtain) limitations of liability clauses, with the result that the choice of contract instead of tort is the denial of liability. Such a result is unacceptable from the point of view of corrective justice and inefficient from an economic point of view (the patient, before going to a doctor, for whatever need, would have to buy self-insurance).

The contrast between the two arguments is very clear. According to Epstein the correct way to resolve the malpractice crisis and build a rational system is contract. According to Schwartz, on the other hand, the malpractice crisis is not due to tort law and the shift towards contract would be both unfair and inefficient.

2.2 The English approach

English writers on medical negligence like to start from certain medieval cases. In *Waldon v. Marshall* ([1370] Y.B. Mich. 43 Ed. 3, f.33, pl.38), the claim was that "*praedictus Johannes manucepit equum praedicti Willelmi de infirmitate, et postea praedictus Johannes ita negligenter curam suam fecit quod equus suus interit"*. Although the main issue raised is whether the claim fitted the form of action, it should be noted that this first case of veterinarian liability was based on the writ of trespass on the case. This also because a general action for breach of contract was to emerge only a few decades later (Marshal's Case [1441] Y.B. Hil 19 Hen. 6, f. 49, pl. 5). In the *Surgeon's Case* ([1375] Y.B. Hil. 48 Ed. 3, f. 6, pl. 11) where the claim was that of the negligent

treatment of a hand, the defendant's defence was that he had not undertaken the obligation to heal the plaintiff. Although the claim was rejected on procedural grounds it should be noted that it was presented as trespass on the case.

This original ambiguity of English law is present also in modern times. The action is non-contractual, but once a contract has been proven one could base one's claim on its breach (JACKSON, 2006). Although this opportunity is only rarely seized, it is important to note that both are available to the plaintiff, but only if there has been a doctor/patient relation, and therefore not when the therapy or the surgical act fall within the national health service (NELSON JONES – BURTON, 1995; JONES, 2003).

Medical liability is strongly influenced by the general restrictive tendencies of English law: the main defence of the defendant is that he has correctly performed his activity. To this one can add a very strict application of the *condicio sine qua non* principle which includes the need, for the plaintiff, to prove that the damage was foreseeable (for more cases see HOCKTON, 2002; JONES, 2003; NELSON-JONES – BURTON, 1995; and essays in FRECKELTON – MENDELSON, 2002).

The restrictive tort law might suggest that the damaged party would be favoured by a contractual approach (JONES, 2002). But as the experts on the sectors point out, there are no appreciable advantages. The obligations which the doctor will have undertaken in the contract will reflect the duty of care of tort law, and in any case the plaintiff will have to confront all the causation difficulties which are common to tort law (KENNEDY-GRUBB, 2000, p.272). One of the reasons is that as the contract between the doctor and his patient is oral, in order to establish its content one has to supplement it with implied terms, generally drawn from the principles of professional diligence used in a tort context (GRUBB, 2004, p. 318).

This attitude of equivalence of actions is well expressed by an English author who has written among the richest and most fascinating pages of private law in the second half of 20th century, Patrick Atiyah. When asked to comment, from an English perspective, on the US malpractice crisis, these are Atiyah's remarks (ATIYAH, 1986), which are extremely interesting from a comparative law point of view:

i. In the first place there is constant osmosis between contractual and non-contractual remedies and they are alternatively used in order to overcome obstacles found in the other field. This relationship has been influenced, in the common law, by the common origins of the actions of trespass on the case and of assumpsit, but can be found also in others such as the producer's liability, which moves from tort to lack of implied guarantees [for an Anglo-German comparison see MARKESINIS- UNBERATH, 2002)].

ii. In common law jurisdictions the preference towards tort, rather than contract, is due to the need to overcome recurrent problems of consideration and privity of contract.

iii. The law of contract – contrary to Epstein's assumption – does not concern only the enforcement of promise and the creation of reasonable expectations, but has gradually been filled with social values and distributive functions. One is therefore mistaken in opposing contract, as the province of individual freedom, to tort, as that of court-imposed liability.

iv. Market efficiency is ensured not only by voluntary and rational choices made through contract, but also by other rules (typically sanctions).

v. There are at least three reasons that have led an essentially contractual relationship towards tort rules:

vi. damages to the person as a special and comprehensive category

vii. the fact that whatever the relationship between doctor and patient, and wherever fulfilled, the standard of care is, and must be, identical;

viii. the complexities due to the fact that not only are many persons involved in health care services, but also products and instruments, each of which might give rise to further damages.

ix. There is always an informational imbalance between doctor and patient, which makes efficient contracts extremely difficult to reach. Furthermore, in the case of minors it is doubted that, in a contractual context, their parents may forfeit their rights to action in consideration of a price reduction.

x. To imagine that the imbalance of knowledge and of contractual power between doctor and patient may be corrected by general agreements among entities representing each side of the contract, means denying one of the principles of contractual freedom, i.e. the adaptability of contract to the specific needs and characteristics of each party. One will simply have standard services for standard patients.

xi. The relationship between doctor and patient is generally a long-term relationship and there is a strong disincentive for the patient to change "his" doctor who has all his medical data and is better able to diagnose and suggest a therapy. This implies that the market is much less flexible and dynamic than others.

xii. If the reason for abandoning tortious liability is that it establishes standards of care which are too difficult to attain, and that in general it favours patients over doctors, there is no evidence that in shifting to contract law the same principles of professional diligence will not continue to be applied.

xiii. According to Atiyah the US malpractice crisis, rather than being the result of a mistaken choice between contract and tort, is the result of what might be called a sorcerer's apprentice syndrome: too many expectations of reform have been laid upon the courts, over-estimating the scope of judicial activism.

Atiyah's remarks show that in two jurisdictions, belonging to the same common law family, which choose the same solution (tort and not contract) for the same problem, the difference is one of 'mentality', a concept which is not clearly grasped in the mostly self-sufficient American legal culture (MILLER, 1985).

2.3 The French contractual approach

Atiyah's critical remarks can readily be confirmed by looking at the French experience, where the contractual approach was adopted long ago.

It is interesting to note that this choice is based on arguments that are similar to those put forward by Richard Epstein. If the parties have voluntarily agreed on certain terms there is no reason to alter their binding agreement with the choices of third parties (the

leading case is Cass. Civ. 20.3. 1936, Mercier). To be sure French judges and academics were not, at the time, influenced by any law and economic approach, and their solution appears to satisfy their *esprit de geometrie* rather than their *esprit de finesse*. Rather it indicates the clear intention to avoid the dilemma between the two available actions, for the case might be considered at the same time as a breach of contract or a tort. The *Cour de Cassation* solves the problem at its root: if there is a contract, contract law and remedies prevail. However it should be noted that what is won by simplifying from a procedural point of view, is lost from a competence point of view because all medical accidents which occur within a public structure fall under the jurisdiction of the Conseil d'Etat (CLERCKX, 2001).

At any rate opposing contract to tort is not particularly fruitful: both case law and scholarly writers work out and polish the distinction between *obligations de resultat* and *obligations de moyens*. At the end of the day the results are not very different whether one applies article 1147 of the *Code Napoléon* (on contractual liability) rather than the catch-all tort provision in article 1382.

The equivalence can be noted by looking at how French case law has moved towards a system of strict liability. First of all by imposing on the doctor a duty to inform his patient, and by the further burden of proving that he has fulfilled his informational duty [see Cass. 1ere civ. 25.2.1997, in Gaz. Pal. 1997 jur.274; and in D. 1997 somm.319, with comment by PENNEAU; and especially the arrêt Clinique du Parc, Cass. 1ere civ. 7.10.1998, in Gaz. Pal. 1999 somm. 317; and D. 1999 jur. 145 (with comment by PORCHY) and D. 1999, somm. 259 (with comment by MAZEAUD)].

The main change is made by shifting the burden of the proof onto the defendant in at least two cases:

i. When the damage is the consequence of hospital infections, i.e. those infections which were not present at the moment of admission to hospital and which are detected at least 48 hours after admission [see Cass. 1ere civ. 20.5.1999 (in Gaz. Pal. 1999, jur. 678); Cass. 1ere civ. 13.2.2001 (in Gaz. Pal. 2002, jur. 512 with comment by CHABAS; and in D. 2001, somm. 3083, with comment by PENNEAU)].

ii. Damage that has been caused by medical devices used during surgery or provided by the medical institution.

It is interesting to note that judges, in such cases, speak of "*obligations de securité-resultat*" which are beyond the contract between doctor and patient.

In these cases the doctor can free himself from liability only by proving that there is an anomaly which has made damage to health inevitable (Cass. 1ère civ. 23.5.2000, in Gaz. Pal.2000, jur. 2449).

Case law goes on establishing that medical obligations must bring about the expected result when execution is not subject to a "strong uncertainty" (GONTIER, ICARD, PANSIER, 2002). The *Conseil d'Etat* has defined the notion of "*alea therapeutique*" (therapeutical uncertainty) as "a risk which is known but is exceptional and there is no reason to believe that the patient is exposed to it in a particular way" "[thus the *arrêt* Bianchi of 9.4.1993 (in JCP 1993,II, 22061 with comments by MOREAU)]. The rule has not, however, been followed by the Cour de Cassation [see Cass, 1ère 8.11.2000, in JCP 2001 II 10493 with comments by CHABAS; e JCP 2001 I 340 with comments by VINEY], creating a significant difference of regime according to the nature – public rather than private – of the institution in which the damage has occurred. According to

the *Cour de Cassation* there is a "therapeutical uncertainty" when an accidental risk occurs within the medical act and cannot be controlled. This is the reason why no liability can be affirmed.

The contrast has given rise to a profound debate among the main French scholars. According to Genevieve Viney the result is a modification of the notion of fault. It will be found in a growing number of cases in order to award damages to the victims of medical negligence. This will bring about increased conflict between doctors and patients that can be solved only by Parliament (VINEY in JCP 2001 I 340). Francois Chabas indicates that the idea of "therapeutical uncertainty" is based on the absence of fault by the doctor, and the notion is unnecessary because that of "*obligation de securité-resultat"* has been sufficiently stretched (CHABAS, in JCP 2001 II 10493). The solution is, therefore, the creation of a compensation scheme for victims of medical negligence, or self-insurance by the doctors (LARROUMET, 1999). Jacques Penneau points out the negative effects of the notion that introduces "an incredibly undetermined definition of damage", inasmuch as it does not clarify whether it includes all the damage that results from the unpredicted deterioration in the patient's condition (PENNEAU, comments to Cass 27.3.2001, in D. 2001,3083). Denis Mazeaud summarizes the position of the Cour de Cassation: there can be liability without fault, but there cannot be liability without causation (as in the "therapeutical uncertainty" cases). Therefore "it is up to Parliament, in order not to leave victims without compensation, to create a compensation scheme which is based not on the rule of liability but on that of solidarity. Compensation schemes, self-insurance: solutions are not lacking, but time is running short" (comments to Cass. 8.11.2000, cited, in D. 2001, 2236).

Rarely have requests by academic scholars been granted so rapidly. On March 4 2002 the French Parliament voted the 2002/303 law "on the rights of the patient and the quality of the health care system", called Loi Kouchner after the name of the minister of health of the time. The law is extremely complex and spans over one hundred articles and many administrative, social security and deontological issues.

For the purpose of this paper the most relevant provisions are:

- *a)* Article 1 which establishes the limits of wrongful birth claims and excludes actions for wrongful life.
- *b)* Article 11, which regulates in an extremely detailed way informed consent, both in its content and its proof (which must be established by the doctor or by the medical institution).
- *c)* Article 98, which introduces a legislative regulation on "compensation of damage as a consequence of medical risks". The principal rules are:
  - *i.* physicians and medical institutions are liable only if they are at fault, except in cases where the damage arises from a product ;
  - *ii.* medical institutions are always liable for hospital infections unless they prove that they are the result of force majeure;
  - *iii.* if a patient has suffered serious damage (over 25% invalidity) which is not the result of fault or of a medical infection, he has the right to receive a sum for compensation awarded for "national solidarity";
  - *iv.* members of the medical profession who have a private practice and private undertakings in the field of medical services must be insured for liability towards third parties;

v. mandatory mediation procedures are introduced; if the mediation commission finds that there has been liability it invites the insurer to settle the claim; if it does not find liability it indicates the compensation sum that must be offered to the patient.

In summary: liability arises from fault which must be proven by the patient, except for hospital infections. "Therapeutical uncertainty" does not give rise to an action but when it entails serious consequences an indemnity is awarded. Litigation is guided towards ADR. The weighting of damages awards is covered by a system of compulsory insurance (BERNARD, 2003; ANGELETTI, 2003; CAILLE, 2003).

All for the better? If one is to judge from the number of critical comments, there are reasons to doubt it. Some authors challenge the way mediation commissions are designated and their procedures (BERTELLA-GEFFROY, 2002). Others believe that the new law has unified the two jurisdictions, civil and administrative (COELHO, 2004). Some others describe the law as obscure "in the whole, in the notions that its authors have not defined, in its procedures". And when it is not obscure it is ambiguous (MEMETEAU, 2005). Age-old principles on causation are subverted (VAYRE-PLANQUELLE- FABRE, 2005). In any case it is less protective of patient's rights than the previous case law, especially in those cases in which an "*obligation de securité-resultat*" was affirmed. Contractual liability is no longer the rule (DREIFUSS-NETTER, 2002). And so is the rule of full compensation to parents for lack of information on foetal malformations [see App. Amm. Parigi 13.6.2002 (in Gaz. Pal. 2002 doct. 1714)]. The courts do not abide by the legislative change and try to reaffirm their domain (TERRIER, 2005) by ignoring the text of the law [see App. Parigi 7.10.2004 in Gaz. Pal. 2005 somm. 1382 (with comments by VRAY)].

2.4 The Canadian experience

In a comparative survey one cannot ignore the Canadian experience, which in the sector of medical law is also extremely rich and instructive, because of its mixed (common law/civil law) legal system and the generally open-minded attitude of most of its scholars. The co-existence within the Canadian federal state of English-speaking provinces and the great French-speaking province of Québec creates an extremely interesting blend of rules (KNOPPERS, 1989; JUTRAS , 1990; GILMOUR, 1994) .

In the common law provinces, the tortious approach prevails. However there is considerable attention paid to the contractual approach, creating, sometimes, uncertainties over the cause of action [see Allard v. Boykhowich [1948] 1 WWR 860 (Sask. KB)].

At any rate, as only very rarely are the terms of the contract specified in writing, the courts supplement implied terms giving rise to what in civil law terms would be considered as an *obligation de moyens*. At other times the claim itself aims to challenge the failure to achieve a certain result (BERGQUIST, 1983). In judicial practice the plaintiff often tries to act on both grounds (contractual and non-contractual) but the result – according to commentators (PICARD – ROBERTSON, 1996, p. 344) – is substantially similar. There are however some cases in which the contractual action appears to be more attractive because the plaintiff need only claim non-performance, shifting the burden of proof onto the defendant. Or he may act only for the loss of an opportunity, without having to prove damage. Or he may need a longer limitation period. On the other

hand an action in tort gives wider scope for damages, including for unforeseeable loss (PICARD – ROBERTSON, 1996, p. 344).

In Québec one may note differing opinions among some of its leading private law scholars (PICARD – ROBERTSON, 1999): while Paul-André Crepeau opts for the contractual approach (CREPEAU, 1956), Jean Louis Baudouin prefers the tortious approach (LAJOIE- MOLINARI-BAUDOUIN, 1983; BAUDOUIN, 1991). Case law is similarly equivocal: after adopting many decades ago the principle of *res ipsa* in a tort context (Parent c. Lapointe [1952] RCS 376), in more recent times it has asserted the existence of a contractual relationship between patient and hospital [Lapointe c. Hôpital Le Gardeur, [1989] RJQ 2619 (App)], and sometimes recognized that there is an *obligation de resultat* [Hopital de Chicoutimi c. Battikha, [1997] RJQ 2121 (App)]. It has also imported from France the notion of *obligation de securité* [(Rizk c. Hopital du Sacre Cœur de Montreal [1999] RRA 197 (CQ)].

The variety of experiences and approaches has suggested some scepticism about the possibility of changes: "One cannot over-estimate the reforming power of the law" (JUTRAS, 1990, p. 841). But there has also been a critical appraisal of the causes of the increase in litigation and of its real impact (DEWEEES–TREBILCOCK-COYTE, 1991; ROBERTSON, 1994). One can readily understand that if the Epstein hypothesis were correct the litigation statistics ought to be much lower in Québec than in the other provinces.

2.5 Scandinavian compensation schemes

To conclude one must briefly take into account the situation in Scandinavian countries where review of the role of damage awards in medical liability led, decades ago, to a general legislative reform of the sector. The Scandinavian experience is furthermore to be taken into consideration because it clearly inspires models of public compensation schemes, such as that which has been introduced in France in 2002.

Starting in Sweden, but then in Finland, Norway and Denmark, since the '70s parliament has passed laws which create a clear connection between health care and social security and therefore introduce compensation schemes for accidents in a medical context. These systems are necessarily no-fault and this is one of their explicit aims; they tend to become part of a general "charter" of patients' rights, which has subsequently been imported by other European countries (RYDDING, 1999; FALLBERG, 2000).

The 1975 Swedish law on *patientforsakringen* (OLDERTZ - TIDEFELT, 1988), is the oldest and requires that medical institutions be insured (insurance became compulsory in 1997) against damage that may arise from their activity. The insurance policy covers cases in which the damage arises from an unexpected worsening of the patient's condition; when it is related to some defect in medical instruments or machinery; in the case of mistaken diagnosis; in the event of hospital infections; and in general for damages which are connected with health services. The ceiling fixed for compensation awards was €500,000 per person for physical damage and for psychic damage arising therefrom. Once the accident has been declared – most commonly by the insured health institution – the insurance company makes an offer to the patient. If the offer is not considered satisfactory the patient may present the case to a commission in which both patients' interests and local communities (which finance public health institutions) are represented. The decision of the Commission is then sent to the insurance company, but is not binding. If the patient is still dissatisfied he will have to appeal to a special arbitration

court. Some statistics may be interesting, but one must take into account the fact that Sweden has only 9 million inhabitants. In the first 20 years after the law was introduced over 100,000 cases were examined. Of these about 3000 were referred to the commission, and not more than 300 appealed. The estimated cost was around €174 million, of which 38% is for physical damage, 18% for further medical expenses, 17% for loss of income and 27% for non-patrimonial damages (FALLBERG – BORGENHAMMAR, 1997).

The Danish model, which was enacted in 1987 but became operative only in 1992, is slightly different because the patient may, from the beginning, bring his claim before the courts or, alternatively, on the basis of the *patientsforsikringsforeningen*, seek compensation from the consortium of insurance companies which runs the scheme (SEGEST, 1996; ERICHSEN, 2001). From a subjective point of view the scheme covers only accidents which have occurred within public health institutions. From an objective point of view it covers not only cases in which there has been negligence, but also: those in which treatment has been below the standards expected of a specialist in the field; when the complication would not have arisen if an alternative, but equally accepted, therapy had been followed; and when an abnormal worsening of the patient's condition has occurred. Commentators note, however, that the decisions of the compensation scheme appear to be strongly influenced by those of the courts in similar cases and that it can be considered a no-fault system not so much because of the facts of the cases brought before it (the majority of compensations arise from cases of negligence) but because in its decisions fault is never mentioned (SEGEST, 1996).

In the Danish system there is also a ceiling to awards, which may amount to about €400,000. Working disabilities which do not reach a 15% level are not considered. Patients over 55 years of age receive reduced compensation.

The decisions taken by the compensation scheme may be appealed to a mixed commission sitting at the ministry of health. Finally, the latter's decisions may be appealed to the supreme court.

If one looks at claims brought in the ordinary courts it has been pointed out (SEGEST, 1993) that Denmark exhibits a procedural aspect which has substantive effects: the parties must present the court with medical expert affidavits concerning the causes of the accident and the negligence of the doctor. If these affidavits are in conflict the judge will generally seek a further advice from a forensic council, a semi-public organ, which therefore, *de facto*, tends to establish the rules in the field of medical liability (SEGEST, 1996). One must also point out some decisions of the court of appeal, which have established that in cases of severe consequences arising from routine medical interventions the burden of proof is shifted onto the defendant (SEGEST, 1996). When the claim is related to organizational malfunctioning of the health care system it is generally brought before an Ombudsman (SEGEST, 1997).

In 1988 Norway introduced a fund for the compensation of damage to patients, entirely financed by the State. It is based on no-fault criteria and, in contrast to what happens in other Scandinavian countries, it does not have an insurance basis. The fund is the result of an agreement between the ministry of social and health affairs and local authorities, which run the health institutions (JORSTAD, 2002). In order to receive compensation there must be a causal link between the treatment and the damage suffered, unless it is a typical consequence of that kind of therapy and treatment has been professionally adequate. If, however, the damage is of a kind not ordinarily related to that treatment, it is possible to award compensation. No ceilings are fixed but only damage to

the person and loss of income are covered. If there has been no loss of income only damage above 15% of working ability can be compensated.

The patient may, in any case, bring his case before the courts if he claims there has been negligence on the part of the physician (SONDERLAND, 1996).

In Finland the patient may bring his claim before the courts but may also address his request to a patients' compensation fund created in 1986 by Law no. 585/86 (KOKKONEN, 1989; KOKKONEN, 1994).

The fund is run by the insurance companies, but covers also accidents which may have occurred in institutions which are not insured (a rather rare circumstance, as insurance is compulsory for both institutions and professionals). Compensation is payable on a no-fault basis and therefore on the mere occurrence of a mishap. However, damage arising from what is considered the normal and foreseeable risk of the treatment is excluded. Compensation covers medical expenses, loss of income and of maintenance, pain and suffering, permanent invalidity, permanent disfigurement, and funeral expenses. The decision of the fund may be appealed before a government commission or before the courts (MIKKONEN, 2001; MIKKONEN, 2004).

While there are positive evaluations of many of these models, especially the Norwegian and Finnish, criticism is levelled against no-fault systems because – so it is said (FALLBERG – BORGENHAMMAR, 1997) – they do not create any incentive for the improvement of the quality of services by doctors and paramedics. As for the various commissions to which the evaluation of the compensation awards is entrusted one of the main criticisms is their lack of transparency (SEGEST, 1996).

3 Some conclusions

This very cursory survey, of three among the most important legal systems of the Western legal tradition, suggests some conclusions, starting from the paradox that in those systems which have a remedy in tort many would prefer one in contract and vice versa; and in which compensation schemes are seen as the fruit of the loom, but immediately upon tasting it, they repent. If one used literary categories one would call it a comedy of errors (both medical and legal): tort and contract are two brothers divided at birth. Each is held liable for doing what the other does, or is expected to do what is his brother's duty. Mistaken one for the other, they undergo endless tribulations. And the same may be said for their two servants, insurance and compensation schemes.

Moving to a less poetical analysis, the conclusions are various.

a) The equivalence of remedies

One of the principal results of comparative investigation on liability is confirmed: the damaged party – and his lawyer – do not care about – and have never cared about – the theoretical implications of the action they choose. They have always opted for the course of action which, according to the circumstances of the case, appears more promising: in terms e.g. of standing, both of the plaintiff and of the defendant, time limitations, burden of the proof, damages awardable. This choice is not made on the basis of abstract and academic speculations, but on the basis of practical experience developed in the courts and through case law. When one of the roads has appeared to be impracticable recourse has been made to alternative remedies, both in private law (such as unjust enrichment)

and public law (special funds, compensation schemes and the like). Second-best choices, but not discarded, especially in the light of the damage actually suffered. In each legal system the inter-relation between the different remedies results in an expansion of one when another shrinks. At the end of the day the overall area covered by damage/compensation systems will be substantially similar, although the different sums liquidated may vary (GROSSEN – GUILLOD, 1983).

From this point of view the statement that contractual and tort remedies are equivalent is correct, not so much from a national perspective (as we have seen in France tort remedies are excluded from the outset) but more from a comparative law perspective.

In fact all the systems examined are similar to each other. In the Western legal tradition, whether of common law or of civil law, the rules of medical negligence are created by the courts. This is quite obvious if one looks at tort liability, which, even in civil law countries, is based on a very limited amount of written provisions; much less if one looks at contractual liability. The content of the contract between doctor and patient, generally oral, is entirely set out by the courts. There are no form contracts, or contractual practices which could be examined to establish what are the common and implied clauses of that specific market. The courts decide when there is a contract, between whom it has been agreed, what its conditions and warranties are, which the rules of liability are, how the burden of the proof is allocated, what damages may be awarded. Obviously general principles are recalled but only to provide a framework for a great deal of judicial creativity.

From the judge's perspective, medical liability is only one among many social and economic relationships brought to his attention and which he must decide. His decision is inevitably influenced by the role the judge has – or believes he has – in each society when he must settle controversies and establish a balance among competing interests.

To describe this in a very legal-realistic way the shape of medical negligence law is, much more than a fragment of a legal system, a mirror, which reflects the idea the judge has of his role.

Therefore it quite irrelevant if the actions are grounded in tort rather than in contract. Not because the rules are the same (we know they are not) but because the judge will use them in accordance with the objectives he feels it proper to attain (DEWEEES – TREBILCOCK- COYTE, 1991).

When the judge feels that the positions of patient and doctor are on the same level, he or she will limit him/herself to applying general rules of tort or of contract. When, instead, he feels that the interest of the patient is the expression of paramount values (constitutional, human rights, etc.) he will modify the rules, metaphorically putting his finger on the scales of justice, and modifying, as he does in many other cases, the rules on causation or on the burden of proof.

It is not the contractual system that leads – or can lead – in a certain direction, as Epstein's dogmatic and ideological approach suggests. Nor does tort law ensure results which are individually and socially more acceptable, as Schwartz optimistically believes. To use yet another metaphor, nobody has doubts about the differences between two means of transportation such as an automobile (which is the expression of private autonomy) and a bus (which represents public regulation). But the two means of transport do not, to any appreciable extent, determine the final destination of the journey, which is instead decided by the driver. In our case, the judge.

In the field of medical liability the results, therefore, do not depend on the legal regime applied to it, because they can be – and are – just as easily reached by manipulating the rules of contractual or of tort liability.

This does not imply that the framework of rules is immaterial. It simply means that the choices made by the courts should be evaluated by different parameters.

First of all one should look at the intrinsic coherence and extrinsic credibility of the decisions that are made. In medical liability cases two primary interests are in confrontation. On one side, life and physical well being that no monetary award will really be able to compensate. On the other side, science, and those who practice it, which is based – in accordance with its epistemological roots, which have assured its extraordinary development – on uncertainty, on the incompleteness of results, on the individual features of each patient. If one were to adopt a Galenic/ Aristotelean approach medical liability would arise in any case in which the doctor has deviated from a dogmatic principle. From Vesalius onwards the experimental and inductive approach on which modern medical science is based makes it difficult to create a dialogue with theoretical and deductive approaches that are typical of legal reasoning, especially in the civil law tradition.

The judge's decision must appear "just" not only because this is the ultimate goal of justice, but also because the victim, or his relatives, must be able to understand the difference between liability and fatality. At the same time the physician – and his colleagues – must be able to extract from the decision a rule of conduct which can actually be applied in future circumstances. It would be mistaken to believe that in medical litigation only the patient has a non-pecuniary interest – health – which he is forced to convert into a damages award because of the doctor's negligence. In his conflict with his patient the doctor has much more to lose than his money and his reputation, and that is the very essence of the medical profession.

A second parameter that should be used in order to evaluate judicial choices is that of their systematic effects. If the decisions are convincingly argued they will meet with widespread social approval. It is however necessary to verify whether, in establishing some special rule for the doctor/patient relationship, they are coherent with the rest of system. What should be avoided are "domino effects" by which a rule which has been thought of in order to solve problems in a specific sector, extends itself to other sectors which cannot be considered as delicate and important. This risk is particularly clear when case law forges general principles – e.g. *res ipsa loquitur*, proximity with the evidence, *securité-resultat*, "easy to perform" obligations – which might not apply at all in different circumstances.

The third parameter, often neglected, is that of judicial statistics. In order to evaluate the efficiency of a model, how it has evolved, its changes in respect of the past, one needs reliable and consolidated statistical data. In the field of medical liability the data that are required are: how many cases, against whom (individual physicians, private undertakings, public institutions etc.), in which fields of specialization (DEWEEES – TREBILCOCK- COYTE, 1991), for what kinds of mishaps, with what outcome. Without this information one does not know where one comes from, and one does not know where one is going. Forecasts are like those of a haruspex, and reform proposals are similar to those of a diviner.

b) Do we need public compensation schemes?

What has just been said downscales considerably criticism of the change in direction by the Italian *Corte di Cassazione*. The strict contractual approach is surely not the cause of any national malpractice crisis. But at the same time one should point out it does not open the road to public compensation schemes. Even if the main purpose were that of deflating litigation, data on the success or failure of the recent French reform is still too meagre. One should also consider the fact that in certain cases that have created wide public concern – such as damage to health ensuing from compulsory vaccinations, or transfusions of infected blood by public health institutions – the Italian Parliament, in common with others in Europe, has passed special legislation in order to compensate victims.

Furthermore, would-be reformers of the medical negligence system should take into account the fact that it represents only one of the many facets of a complex system, mostly governed by administrative bodies and rules, aimed at providing all citizens with an adequate level of health care (MARKESINIS – DEAKIN, 2003). And that health law, just as most areas of the law, is subject to increasing intervention by EU institutions, with the aim of harmonizing the level of health care (HERVEY – McHALE, 2004; NYS, 2001).

On one count, however, the debate should be deepened: in a system in which most health services are rendered by public institutions, is full compensation of medical errors justifiable? On the one hand it might be argued that natural justice prevents us from discriminating between damaged persons according to where (a private or a public institution) they have suffered their damage. And it might be added that in those regions or countries in which higher levels of health care are rendered by private undertakings, this would imply that those who do no not have the means to pay for them would be under-compensated in the case of medical negligence.

On the other hand one must insist on the fact that paying full compensation to patients injured in a public health institution simply means transferring the damage onto the taxpayer or, worse, reducing the budget of the national health system. Court decisions have a very limited deterrent effect (even in the US: MELLO – BRENNAN, 2001), not least because in many cases the injury is due to organizational dysfunctions (HARPWOOD, 2001, p. 58), against which the individual doctor cannot intervene, other than through an even more damaging (for the patient's health) work-to-rule reaction. Damage awards are therefore deprived of their deterrent purpose and can only have a compensatory one, an aim that could be preserved even if some limitations to the amount of damages were introduced.

The scenario is therefore extremely uncertain. Epstein's remarks over 30 years ago are still valid: " We might once have had high hopes about the capacity of the legal system or of the medical profession to generate a set of rules that would vindicate all just expectations and *only* just expectations; but medical malpractice is a business which, because of the intractable nature of its subject matter, will yield even at its best only very imperfect results. The question is not how we can make the system perfect; that cannot be done. The only question worth asking is how we can make the system better than it is today. Incremental improvements, not messianic reforms, are the order of the day" (EPSTEIN, 1976, p.91).

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