Editorial

The widening gulf between medicine and the law

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As the health care system creaks under the competing forces of rising costs and expanding technology, friction is developing between medicine, the law and medical ethics. The professional liability of physicians used to be clear cut and simple, and the law mirrored this, but the new complexities are raising issues in which responsibilities are blurred, and the previous imperatives of law and medicine may be directly in conflict. Blind adherence by either profession to its own narrow dictates will not serve society well, and failure to design sensible policies on current explosive issues can only harm the public and both professions. A few simple examples of such issues will highlight the problems we face.

Malpractice and "defensive medicine"

No physician would deny the right of a patient injured by medical malpractice to a just and indeed generous award, and we recognize that often this does little to correct the harm done. But physicians, being human, do make mistakes. The medical profession funds the Canadian Medical Protective Association (CMPA) to act for physicians and make recompense to patients affected by mistakes that are deemed negligent. The courts of Canada have begun to award very large sums to individual patients. The amounts are often compounded by "gross-up" for income tax on the awards and by substantial payments to relatives of the injured party. One recent award in Ontario exceeded $3.0 million for loss of a forearm as a result of a tight cast and subsequent infection. These enormous sums must be paid by the medical profession via the CMPA. Furthermore, courts have sometimes awarded large sums to a patient when the patient was harmed by an event falling in the grey zone between malpractice and medical misadventure.[1]

Increasing numbers of awards against doctors are reflected in the large increases in CMPA premiums in the last 3 years; this, in turn, fuels the practice of "defensive medicine" — more tests, more physician time and more return visits predicated on self-protection in the courts rather than real need. Although such practice is often acknowledged, few attempts have been made to quantitate the cost of defensive medicine, which may well be substantial. The additional expense for the health care system will consist of the costs of professional liability insurance, the cost of the changes induced in practice patterns and the cost of additional tests, the latter compounded by the downstream effects of positive test results, both true positive (indicating disease) and false positive (red herrings leading to more unnecessary investigation).

A recent report from the United States suggests that in 1 year the total cost of defensive medicine might exceed $12 billion (US) and account for about 15% of total expenditure for physicians' services. These estimates are confined to the physician component only; the additional cost of tests or to hospitals is unknown. How these data pertain to Canada is uncertain, but the same forces are in operation; the US calculations refer to 1984, when doctors' premiums for professional liability averaged $8400, a figure already exceeded by some doctors in Canada today.[2]

This is not to say that the medical profession advocates defensive medicine. Since most suits against physicians involve failure of communication, usually between doctor and patient, the performance of additional tests will not be an effective preventive measure; indeed, additional tests producing false-positive results, or true-positive results that are ignored because they were not expected, may paradoxically prove to increase liability.

This, then, is an area in which medicine and the law previously operated in reasonable synergy, but recent trends have opened a gap that may become difficult to bridge. Trends in the law are driven by societal shifts emphasizing the rights of the individual and the need for these rights to be

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protected by the courts. Supported by society's increasing awareness of health issues, this trend results in more lawsuits and promotes larger individual monetary awards. The medical profession does not, of course, oppose such concepts, but it is harried by other changes that push practitioners into increased legal and financial risk. These changes include the increased complexity of medical care, the almost unlimited expectations of the public, the ethical problems posed by the rules governing patients' rights to confidentiality and even the interpretation of the laws of informed consent.

This gap between medicine and the law is reflected in the rapidly increasing cost of malpractice insurance and the undetermined extra cost to society of defensive medicine; the divergence, however, is also affecting the practice of medicine. In the United States, for example, it is suspected that many cesarean sections are done to avoid potential litigation rather than for medical reasons; physicians are reluctant to treat high-risk patients, some operative procedures are avoided, and professional liability may be eroding rather than improving the quality of care.[3] In Canada similar effects are emerging; a reduction in numbers of family doctors willing to practise obstetrics or to administer anesthetics is the most obvious. Pleas by doctors to consider the more distant effects of legal decisions are usually dismissed as self-serving, but at least the influence of liability awards on health care costs to society should be recognized and considered.

Responsibility for quality of care

The public hospitals acts of most provinces delegate to the hospital boards the duty of ensuring that the quality of care is maintained at acceptable levels. This duty is then further delegated to the medical staff organization and the medical advisory committee, which by various audit and quality assurance methods may then assure the board that this function is being performed. As with most aspects of health care what was once simple has become very complex — for example, in the past, hospitals have been able to remain immune from actions directed against their physicians, who have traditionally been regarded as independent practitioners. More recently, however, there has been a trend to involve hospitals in suits against their medical staff; this trend has been promoted by some legal authorities as well as by changes in medical practice such as rotating call schedules and the "health care team" concept, both of which may be seen as the hospital imposing an unknown doctor on the patient.

As a result of the perceived increase in the potential for liability, hospital administrators and boards are naturally seeking more definitive assurance about quality of care and about detection and discipline of incompetent physicians. Hence, the medical staff must step up audit and supervisory activities, with the subsequent risk that delicate and involved information about either doctors or patients may leak out. Medical audits involve examination of patient records, which are protected by the patient's established right to confidentiality. Leakage of sensitive information about a patient's medical history, particularly in small communities, becomes more likely as more individuals become privy to the contents of the records. This is especially true when nonmedical members of the hospital staff participate directly in the medical audit process.

Audit committees and medical staff officers responsible for implementing standards of practice encounter other major difficulties because of the wide gap between the type of poor practice that medical staff organizations would like to correct and flagrant malpractice. When the latter is identified it is relatively simple for medical staff officers to take disciplinary action and to expect support from the hospital board and the law if the physician indicted takes retaliatory action. In contrast, when the issue is one of poor medical practice unacceptable to the medical staff, legal protection for disciplinary action is often lacking.

The legal profession is also swept up in the current vogue of freedom of access to information, and in many provinces it is likely that the detailed working papers of audit committees and internal hospital disciplinary committees may be legally obtainable by the courts. However desirable this situation may be in the abstract, it seriously impairs the surveillance and disciplinary activities required to ensure the quality of care, because participants in the peer review and the hospitals may be at risk of being sued by doctors who are disciplined as a result of this process. This risk is much greater in the United States, where the public insists on close scrutiny of the medical profession; Congress recognized the need to protect hospitals and physicians in peer review functions and thus rapidly enacted the Health Care Quality Improvement Act of 1986.[4] Similar legislation will be required in Canada if we are to do something positive about quality of care and malpractice. Doctors in general are competent and honest and should be in a position to bring to disciplinary authorities cases of medical incompetence with minimum personal legal risk.

As with the malpractice issue, changes in society are tending to separate the professional objectives of law and medicine, objectives that were previously not in conflict. The thrust to make hospitals responsible for the actions of their physicians is driving hospital boards and administrators to become directly involved in patient care and its supervision. This, together with the need for lawyers and the courts to gain access to medical information, infringes on what has traditionally been a domain protected by medicine's rules and ethics. The practical effects of this modulation include risks to confidentiality, damage to existing

audit processes, and increased paranoia and obstructionism among medical staff.

Legal approach to acquired immune deficiency syndrome (AIDS)

Medicolegal disharmony has developed over the vexed question of testing for antibody to the human immunodeficiency virus (HIV). The Canadian Bar Association–Ontario has published guidelines for HIV antibody testing and contact tracing, presumably with some medical input;[5] like most such documents on AIDS, medical ones included, the real questions are not addressed, and the central issues are evaded.

The dilemma in this issue arises from the fact that an individual's rights and the need for confidentiality are in direct conflict with measures aimed at protecting society as a whole. AIDS is clearly a major public health menace and is usually transmitted by sexual intercourse. When a patient is identified as having antibodies to HIV, he or she has the potential to transmit a deadly disease to any sexual partners and has a responsibility to inform them of this fact. If anger, incomprehension or irresponsibility prevents this action, doctors will feel they have the duty to breach confidentiality and allow "discreet disclosure" of the test result to a third party.

The standard public health response to sexually transmitted disease is to make cases of the disease reportable, as has been done for AIDS in Ontario and other provinces, which allows screening to identify affected individuals and initiates the tracing of contacts. These activities are legally protected under the Health Protection and Promotion Act in Ontario.[6] AIDS and HIV antibody positivity are reportable in Ontario but not all across the country. Since the disease may conceivably be transmitted to health care personnel who are looking after infected patients, protection measures are legally defined in the Occupational Health and Safety Act of Ontario:[7] employers are compelled to acquaint the worker with any hazard in the work, including that related to biochemical or physical agents. Increasing concern over AIDS is leading to further pressure from groups of health care personnel for identification of patients with positive results of HIV testing.

Thus, there appears to be an unassailable case for screening, contact tracing and reporting of patients with HIV infection. The other horn of the dilemma, however, comes from considering patients' rights and the confidentiality of information shared between a doctor and patient. The Health Disciplines Act prohibits a physician from revealing information about a patient's condition without the consent of the patient unless specifically required to do so by law.[8] The precise interaction between this legislation and the powers conferred by the Health Protection and Promotion Act on the medical officer of health in regard to AIDS is not clear; certainly a practitioner may not be protected if patient confidentiality is breached in contact tracing. This risk is emphasized by the CMPA and the College of Physicians and Surgeons of Ontario. The argument is given point by the potentially cataclysmic effects of revealing such information — marriages are broken, jobs are lost, insurance policies are cancelled, fetuses are aborted and suicides occur.

The debate is further complicated by the uncertainty over whether identification of contacts will be possible or beneficial. At the moment there is no effective treatment for AIDS, and it is possible that attempts to identify and trace the many contacts of male prostitutes or intravenous drug users will not succeed.

Finally, the ethical and legal dilemma is heightened by scrutiny of the accuracy of AIDS testing. The enzyme-linked immunosorbent assay, when applied to a population like that in Canada, where the incidence of HIV infection is approximately 0.01%, will produce 40 false-positive results for each true-positive one. The addition of the more accurate confirmatory test, the Western blot, will probably produce about 5 false-positive results for every 10 true-positive ones. Thus, the probability that HIV infection is present in a patient with positive results will be only 67%.[9]

This contentious issue differs from those of malpractice and quality of care in that it has arisen because of the appearance of a new and quite different disease, and existing statutes were not written with knowledge of the questions AIDS poses. The decision about screening populations and contact tracing is one that society will have to take, and medicine and the law will have to devise suitable regulations.

Patient advocacy and cost constraints

Perhaps the greatest potential for conflict between medicine and the law lies in a new ethical puzzle that faces all physicians. Until a few years ago physician paternalism was widely accepted; more recently the concept of "patient autonomy" has gained popular and legislative support, probably to the benefit of both doctor and patient. Throughout this time the doctor–patient relationship was left intact, and the doctor was free to act on behalf of the patient as he or she saw fit without external constraint. Now, however, important factors, most of which have been generated by the need to control rising costs, have conspired to change this situation.

In Canada, as in every other developed country, physicians are being pressed to consider society's needs in determining the amount of medical care required by each patient; such consideration seems rational when viewed in the abstract but may create an apparently insoluble problem in a particular case. Doctors are rightly uneasy about the intrusion of cost considerations in clinical

decisions. This is not to say that life must be prolonged under any circumstances, for most would accept that the best medical care may involve restraint in the use of technology when that technology merely prolongs death. This concept has increasing legal support. It becomes a very different matter, however, if the physician either withholds or discontinues treatment on the grounds of cost. It is difficult to imagine any court of law, faced with the issue of harm to an individual, accepting a plea of economic constraint from the defence. Nevertheless, doctors will increasingly encounter the need to impose rationing of services to allow hospitals to stay within global budgets and to meet government targets for restraint in cost increases in health care delivery in general. These decisions will then impinge on clinical practice and will inevitably reduce physicians' freedom to act in their patients' best interests.

Similar trends in the United States have been examined extensively, and Relman[10] believes that in conflicts between altruistic medicine and the financial imperatives of business the latter will win. Many concerns for both physicians and patients result from these changes. If we can no longer afford the provision of everything for everyone, systems of legal protection will be required to allow fair rationing. Removal of the doctor's freedom to act purely on a patient's behalf will soon result in the patient's losing faith in physicians, and an essential element of care will be lost. Patients will not be able to give informed consent for procedures and treatment if cost considerations are concealed from them. The whole fabric of our present system will change if the duty of the physician to the patient is altered.

Bridging the gap

There are no easy solutions to the problems outlined here, but it is clear that the dialogue between medicine and the law must be sharply accelerated. Appreciation of the position of each profession by the other would in itself be an advance and should lead to debate and recommendations on specific issues.

Education about defensive medicine is vital for doctors. Apart from increased costs, current practices are not aimed at the right target, which should be improved communication between patients and all health care workers involved. Malpractice lawyers seem to have become seekers of perfection. They must learn that clinical care is still a relatively inexact science and that not every infant with cerebral palsy owes the affliction to medical mistakes. The cumulative cost of higher malpractice premiums, larger awards to plaintiffs, costs of litigation-inspired tests and the overall effect of trends on medical practice should be carefully monitored. Society may have to find new ways to recompense and support the victims of malpractice and misadventure or of simply the deficiencies in current medical knowledge.

Both medicine and the law will have to intensify efforts to promote adequate supervision of quality of care and professional medical competence. This will require some protection for hospitals and doctors engaged in peer review against the threat of being sued by doctors disciplined as a result of the review process. The issue is a major one, involving hospital boards, administrators, medical staff and patients; it therefore certainly warrants the establishment of a task force to provide sensible recommendations.

Although the AIDS issue potentially places physicians in conflict with the law, the primary duty of the medical profession remains that of providing care for the patient and, it is to be hoped, finding a cure for the disease. The challenge for society is to devise laws that will protect the community as a whole as well as the rights of the affected individual.

The moot point of legal responsibility for the potential harm done to individuals by the nonavailability of medical resources will have to be examined. Physicians have an unambiguous duty to ensure that all resources are conserved and that efficiency is maximized. They should not, however, have to shoulder responsibility for misadventures that may result from financial constraints imposed by third parties.

Many other issues will arise in which the relation between medicine and the law will be tested. Neither profession can afford to try to deal with complex ethical problems in isolation, and solutions must be communally sought, preferably before fixed positions are taken and with open public involvement.

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