Controlling the Costs of Medical Malpractice: An Argument for Strict Hospital Liability

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CONTROLLING THE COSTS OF MEDICAL MALPRACTICE: AN ARGUMENT FOR STRICT HOSPITAL LIABILITY

BY BRUCE CHAPMAN

I. INTRODUCTION

There is cumulating evidence that Canada, as well as the United States, faces an unprecedented rise in the cost of health care delivery. In part, this can be explained by recent increases in the number of complaints about the quality of health care provided by both physicians and hospitals. This increased number of complaints translates into a higher frequency of legal claims for medical malpractice, as well as higher damage awards and settlements, and consequently, into an increase in the costs of liability insurance for

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* Copyright, 1990, Bruce Chapman.
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both physicians and hospitals. In Canada, these higher costs of insurance form part of the negotiations of physician fee structures under the various provincial health plans. Therefore, the increasing costs of medical liability are ultimately borne by all taxpayers in their general funding of the public health care system.

In light of these developments, it is reasonable to think that the natural way to control the escalating costs of health care which are due to medical malpractice is by containing the rise in malpractice premiums. Hence, in the United States, various state legislatures have responded by, for example, shortening the statutory limitation periods, subtracting collateral benefits, imposing restrictions on plaintiff attorney fees, creating screening panels for malpractice claims, and reducing the size of damage awards, either by directly capping the rewards (usually for pain and suffering) or by requiring periodic rather than lump-sum payments. In Canada, there have been demands for comparable legislative responses.

However, it is a mistake to think that higher malpractice premiums will be the only cost of the increased incidence of medical malpractice complaints that will show up in higher costs of health care. There is also to be considered the cost of increased defensive medicine, or medicine that is practiced largely out of fear of legal liability. While this cost can also be controlled by legislative devices designed to reduce the scope of medical malpractice liability, attention to the cost of defensive medicine suggests yet another


3 Sellers, supra, note 2 at 358.

4 For a survey of some of these legislative responses in the U.S., see G.O. Robinson, "The Medical Malpractice Crisis of the 1970's: A Retrospective" (1986) 49 Law & Contem. Prob. 5.

approach to controlling spiralling health care costs. In particular, it suggests a closer look at who should properly be the defendant in the usual medical malpractice action.

In this paper, I shall suggest that our current tort system, which continues to deem the physician as the primary health care provider and, therefore, the primary target for malpractice liability, generates systematic and unnecessary incentives for the practice of defensive medicine, the costs of which, on some estimates, probably dwarf any costs of increasing malpractice premiums. I shall argue that the costs of defensive medicine can more easily be controlled if the burden of liability for physician malpractice is shifted from the physician to the hospital, and the standard for liability is changed from negligence to strict liability. I shall also argue that such a liability regime will reduce the incidence of medical misadventure, and be cheaper to administer on a case-by-case basis than our current system.

Further, strict hospital liability should help to reduce the unfortunate adversarial nature of our health services system. At the moment, our overall scheme of health care delivery and responsibility generates conflicting incentives between physicians and the hospitals in which these physicians work. While hospitals, now largely immune from liability for physician negligence because of the independent contractor rule, strive on limited budgets to contain the increased costs of health care, physicians attempt to avoid increases in expected malpractice liability by practicing more and more costly defensive medicine. It is part of my claim that these diverging incentives can be realigned by moving away from a system of physician negligence rules towards a regime of strict hospital liability.

Nor is it mere crisis management that should have us thinking about expanding the scope of hospital liability in Canada. Gone are the days when a physician was typically called to attend

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6 P. Weiler, Legal Policy for Medical Injuries: The Issues, the Options and the Evidence (January 1988) [unpublished] at 159. See also text accompanying note 54, infra at 544.

7 See section II.B., infra at 531.

8 For an account of the strained relationship that exists between hospital management and medical staff in the United States that is due in large part to a comparable divergence in their respective goals, see B.E. Spivey, "The Relation Between Hospital Management and Medical Staff Under a Prospective-Payment System" (1984) 310 New Eng. J. Med. 984.
to patients in their homes. And increasingly rare are occurrences when patients go first to their doctor before going to the hospital merely on the doctor's recommendation. More and more the hospital, or some comparable institution such as a walk-in clinic, is looked to by the patient as the primary health care provider, with the physician a member of its team; and it is increasingly a part of the patient's reasonable expectation that the hospital or like institution be a place where the patient can expect not only competent staff but competent care as well. This reasonable expectation is further grounding for a system of strict hospital liability for physician malpractice.

Section II of the paper provides a brief summary of the law on hospital liability in Canada. It shows how hospital liability for physician malpractice is currently very restricted. Section III begins the argument for expanding the scope of hospital liability. It argues, in particular, that hospital liability should reduce the incidence of medical misadventures and the costs of defensive medicine. Section IV goes further and suggests that the standard of hospital liability for physician malpractice should be strict liability. Such a standard is cheaper to administer and, again, avoids the high costs of defensive medicine. Section V provides for one exception to the general rule of strict hospital liability. In cases of gross physician negligence, the hospital should be allowed to have an indemnity action against the physician. The paper concludes in Section VI.

II. HOSPITAL LIABILITY IN CANADA: THE CURRENT LAW

In Canada, the civil liability of hospitals for iatrogenic injuries can be established either directly or indirectly. Direct liability is also referred to as personal or corporate liability; it turns on the immediate relationship that exists between the hospital and the patient. Indirect or vicarious liability, on the other hand, is determined in large part by the kind of relationship that exists

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9 E.I. Picard, Legal Liability of Doctors and Hospitals in Canada (Toronto: Carswell, 1984) at 299.
between the hospital and the individual providing the health care to the patient, for example, the physician or the nurse.

A. Direct Hospital Liability

The ordinary principles of negligence apply as much to hospitals as to any other person or institution. This means that in a successful suit against a hospital, a plaintiff must prove, on a balance of probabilities, first, that the hospital owed him or her a duty of care; second, that this duty was breached; third, that the plaintiff thereby suffered a loss; and, fourth, that the hospital’s breach of duty was the cause-in-fact as well as the proximate cause of his or her injury. The hospital then has all of the usual defences available to it including, for example, the expiry of any statutory limitation periods or the contributory negligence of the plaintiff. However, the most critical constituent element of a successful negligence action against hospitals is the duty of care. Depending on how expansively this duty is construed with respect to hospital patients, courts can greatly vary the extent of hospital liability for negligence.

The most general duty of care a hospital owes to a patient is the provision of a "safe system" of health care delivery. Thus, a hospital will be directly liable for injury to the patient from inadequate or improperly maintained equipment, or for failure to provide sufficient personnel to permit adequate rotation of nurses without danger to patients. Moreover, hospitals are also directly liable for any failure to hire competent and qualified staff. This follows from the fact that the hospital holds itself out as a place where patients will be attended to by skilled persons. Thus, the rationale would equally embrace a hospital's duty to provide systems


13 Magnet, "Corporate Negligence As a Basis for Hospital Liability – A Comment on Yepremian v. Scarborough General Hospital" (1979) 6 C.C.L.T. 121 at 124-25.
of review for the continued competence of its personnel, and to take any necessary steps to prevent unqualified personnel from continuing to attend to patients, for example, by withdrawal or restriction of a physician's privileges in the hospital or by the firing of an employee.

However, the real controversy in discussions of a hospital's direct liability to its patients concerns whether a hospital is under a duty not only to provide competent medical staff but also to provide competent medical care. This distinction might appear to be an overly nice one, but it is what finally divided the majority from the minority opinion in *Yepremian v. Scarborough General Hospital*, now the leading Canadian case on this issue. Here the plaintiff sued the defendant hospital after a non-employee internist, with hospital privileges and on call for emergency, failed to diagnose and then properly treat the plaintiff patient for diabetes. As a result, the plaintiff suffered a cardiac arrest and ensuing brain damage. While there was no doubt that the doctor himself had been negligent, the action was directed solely against the hospital. At trial, Holland J. argued that section 41 of the *Public Hospitals Act* clearly reflected "the intention that hospitals be directly responsible to their patients for the quality of care provided in the hospitals." He added that "the Legislature recognizes the institutional responsibility for care as opposed simply to a responsibility for providing staff" and, accordingly, found the hospital liable for negligence. Since there was no evidence that the hospital had been negligent in any way in the selection and supervision of its staff or in the organization of its work, critics of the trial decision argued that this trial holding amounted to a form of strict liability against hospital corporations for negligent medical treatment occurring on their premises, something for which there was no prior Canadian legal authority.

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14 *Supra*, note 10.
15 R.S.O. 1970, c. 378, s. 41, as am. R.S.O. 1980, c. 410, s. 31.
16 (1978), 88 D.L.R. (3d) 161 at 175 (Ont. H.C.).
18 See, e.g., Magnet, *supra*, note 13 at 126.
Moreover, in reversing the trial court’s decision, the majority of the Ontario Court of Appeal seems to have agreed. After pointing out that no court in Canada had ever before found that a hospital directly owed a duty to provide proper medical care to a patient, Arnup J.A. went on:

I agree with the trial judge ... that the Yepremians had every right to expect that a large public hospital like Scarborough General would provide whatever was required to treat seriously ill or injured people, but I do not think that it follows that the public is entitled to add the further expectation: "and if any doctor on the medical staff makes a negligent mistake, the hospital will pay for it."

Rather, I think a member of the public who knows the facts is entitled to expect that the hospital has picked its medical staff with great care, has checked out the credentials of every applicant, has caused the existing staff to make a recommendation in every individual case, makes no appointment for longer than one year at a time, and reviews the performance of its staff at regular intervals. Putting it in layman's language, a prospective patient or his family who know none of the facts would think: "If I go to Scarborough General, I'll get a good doctor." Arnup J.A. argued that if direct liability was to be imposed on hospitals for the negligence of its medical staff, including those not operating as hospital employees, then such a development should be properly legislated as a matter of policy rather than created out of whole cloth by the judiciary adjudicating a particular case.

However, in a powerful dissent, Blair J.A. admitted the novelty of the case but argued persuasively that the failure to expand liability in such a situation also involves the court in a policy decision: "When confronted with a novel situation, the Court makes a policy decision whether it decides to expand the area of liability or refuses to do so. It expresses a view, in either case, as to what ‘ought’ or ‘ought not’ to be done." As a logical point about judicial decision-making in a novel case, it is hard to dispute Blair J.A.'s view.

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19 Supra, note 10.
20 Ibid. at 532.
21 Ibid. at 545.
22 Ibid. at 563.
More significant, however, were the substantive arguments that Blair J.A. advanced for a hospital's duty to provide non-negligent medical care:

The recognition of a direct duty of hospitals to provide non-negligent medical treatment reflects the reality of the relationship between hospitals and the public in contemporary society. This direct duty arises from profound changes in social structures and public attitudes relating to medical services and the concomitant changes in the function of hospitals in providing them. It is obvious that as a result of these changes the role of hospitals in the delivery of medical services has expanded. The public increasingly relies on hospitals to provide medical treatment and, in particular, on emergency services. Hospitals to a growing extent hold out to the public that they provide such treatment and such services.3

Blair J.A. went on to conclude that in the circumstances of Yepremian, the patient had completely placed himself in the defendant hospital's hands, relying on the hospital to use its resources of equipment and skilled personnel to restore his health. In such a case, the hospital's obligation could not properly be limited to the provision of a qualified doctor; rather, the hospital assumed, and would reasonably be expected to assume, complete responsibility for the patient's actual treatment.

Leave was granted to appeal the Ontario Court of Appeal decision in Yepremian to the Supreme Court of Canada. However, the defendant hospital agreed to settle the case for just over $1.8 million.24 According to at least one case commentator, the hospital did this to avoid the risk of an adverse judgment at the Supreme Court level.25 Certainly the fact that the Supreme Court did not get a chance to finally rule on the matter, together with the fact that three of the six judges hearing the case (the trial judge plus two of the five Court of Appeal judges) found for the plaintiff, suggests that the true extent of direct hospital liability for medical malpractice remains largely unsettled in Canada.

23 Ibid. at 579.

24 Picard, supra, note 9 at 322.

25 Ibid.
B. Vicarious Hospital Liability

In addition to the liability that attaches to the duties the hospital owes its patients directly, there is also the possibility that the hospital will be held vicariously liable for the negligent conduct of its employees. Indeed, this is the most common basis upon which a hospital will be held liable to a patient. In its most general form, vicarious liability means that an employer will be liable for the torts of an employee committed within the scope of his or her employment, but will not be liable for the torts of an independent contractor.

It is obvious then that the key issue in this area of liability is what determines whether an individual is an employee or an independent contractor. This is especially important in the hospital context given the presence of a highly skilled and professional staff which typically operates (as in large part it should) independently of any specific directions from the hospital. In an influential, early English case *Hillyer v. St. Bartholomew's Hospital*, for example, the court held that a hospital would be vicariously liable for the negligent acts of its professional staff while they exercised their "ministerial or administrative" duties, but not while they were carrying out their "professional" duties. The reason for the distinction was the perceived absence of control of the employer over the professional duties, something which made the professional staff look more like independent contractors.

Nevertheless, in *Gold v. Essex County Council*, the English Court of Appeal rejected the distinction between ministerial or administrative duties and professional duties as unworkable, finding the hospital liable for the negligence of a radiology technician. Also discounted was the control test for determining the sorts of relationships which would ground vicarious liability. Instead, some sort of master-servant relationship was deemed to be necessary. Why this might be relevant was made more clear in *Cassidy v.*

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28 [1942] 2 K.B. 293.
Ministry of Health, a case where a hospital was held liable for the negligence of a house surgeon employed on its permanent staff. Denning L.J. argued for liability as matter of principle:

... [W]hen hospital authorities undertake to treat a patient, and themselves select and appoint and employ the professional men and women who are to give the treatment, then they are responsible for the negligence of those persons in failing to give proper treatment, no matter whether they are doctors, surgeons, nurses or anyone else.

He went on to emphasize that it was this power of hospitals to choose and dismiss employees which justified the application of vicarious liability even in the absence of any ability to control:

What possible difference in law ... can there be between hospital authorities who accept a patient for treatment and railway or shipping authorities who accept a passenger for carriage? None whatever.... The reason why the employers are liable in such cases is not because they can control the way in which the work is done - they often have not sufficient knowledge to do so - but because they employ the staff and have chosen them for the task and have in their hands the ultimate sanction for good conduct, the power of dismissal.

Whether Denning L.J. thought this liability to dismissal sensibly distinguished employees from independent contractors was not made absolutely clear, although Denning L.J. later made certain observations which indicated that he thought such a distinction artificial in hospital cases.

The real source of the distinction between vicarious hospital liability and independent contractor liability, at least in the English cases, now seems to turn on whether the physician, rather than being provided by the hospital as an integral part of its overall organization of health care delivery, was engaged directly by the hospitals.

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30 Ibid. at 362.
31 Ibid. at 360.
32 Ibid. at 362. Rozovsky has also noted that hospitals have the same powers of sanction over the independent contractor doctors to whom hospital privileges have been granted as they do over their employees. See L.E. Rozovsky, "The Hospital's Responsibility for Quality of Care under English Common Law" (1976) 24 Chitty's L.J. 132 at 133. See also J.B. McHugh, "Risk Administration in the Marketplace: A Reappraisal of the Independent Contractor Rule" (1973) 40 U. Chi. L. Rev. 661. This close analogy between employees and independent contractors is important for the discussion in section V, infra at 565.
patient.33 This would explain why in a third English case, *Roe v. Minister of Health*,34 the defendant hospital was held vicariously liable for the negligence of an anaesthetist even though he carried on a private practice and was only employed by the hospital part-time. The problem with this as a rationale for vicarious hospital liability in Canada is that it would suggest the hospital should have been held vicariously liable on the facts in * Yepremian.* Yet the majority of the Court of Appeal rejected vicarious liability in that case, and the minority seems to have based its findings of hospital liability on a duty which the hospital directly owed to the patient.35

Thus, in Canada we are still waiting for a systematic and coherent account of the grounds for vicarious liability that allows us to make sense of why and when a hospital should be held liable for the negligent conduct of its personnel. In the remainder of this paper, I hope to provide the beginnings of such an account. We shall see that Denning L.J.'s "power of dismissal" serves to imply hospital liability as much for the misconduct of physicians who are independent contractors as for the acts of employees in some kind of master-servant relation. In other words, the analysis to follow argues for an expansion of vicarious hospital liability, but in a way that does not depend on the problematic distinction between independent contractors and employees.

III. THE ARGUMENT FOR HOSPITAL LIABILITY

In this section, I shall argue for an expansion of institutional liability in the context of medical malpractice. By institutional liability, I mean a harm-based liability rule36 that targets the

33 See *Yepremian*, note 10 at 574, Blair J.A.


35 See text accompanying note 23, supra at 530.

36 The cumbersome phrase "harm-based liability rule" is used in place of the phrase "tort rule" to indicate my concession to the view that a proper understanding of tort law cannot involve the kind of deterrence theory I use in this paper. Deterrence theories, as well as compensation theories, look upon the fortunes of plaintiff and defendant as separate from one another, whereas a true tort theory would essentially link each party to the other and give each equal standing in the private law action. Ernest Weinrib has convincingly argued that
institution in which individuals work. In medicine this obviously suggests the hospital, but there are reasons for also considering other levels of institutional liability which are intermediate to the hospital and the individual worker. This might include, for example, the different departments or sections within the hospital, or even the various sub-groups of individual hospital staff members deemed to be in some sort of partnership relationship with one another.

Throughout my discussion, I shall assume that the goal of a health care liability system is to provide incentives to reduce the frequency of incidents giving rise to medical misadventure. I take it as proven that if a liability system were only to provide compensation for victims of iatrogenic injury, it would be a very poor compensation system indeed. It seems odd to channel malpractice compensation through a determination of physician liability and then, at least in Canada, to have that physician collect the costs of providing that compensation through fees which are determined and, ultimately, paid for by the government. Surely a better system, at least if compensation is the only goal, is to bypass any determination of physician malpractice altogether, with all its attendant legal fees, and go directly to some sort of social insurance plan.  

Nevertheless, even if a reduction in the overall frequency of medical malpractice is the only sensible goal of a liability system, that goal cannot be pursued without giving due attention to two other sorts of costs. First, there are the direct costs of avoiding medical misadventures. Our goal cannot properly be the reduction of medical malpractice at any price; rather, it must be something more akin to the optimal reduction of medical malpractice, that is, reduction to a point where (at the margin: see section III.B below) such a true theory of tort is to be found in the idea of corrective justice, whereas the theories of deterrence and compensation are essentially theories of distributive justice, focusing on the defendant and plaintiff respectively. See, e.g., E.J. Weinrib, "Liberty, Community and Corrective Justice" (1988) 1 Can. J. L. & Juris. 3. This is also why the scheme of strict hospital liability that is finally proposed in this paper must be one that is legislated. It is not a scheme appropriate to discovery within the confines of tort law adjudication.

37 Danzon has estimated that roughly sixty-six cents of every dollar that reaches plaintiffs as compensation is spent by the parties on litigation. See P.M. Danzon, Medical Malpractice: Theory, Evidence and Public Policy (Cambridge, Mass.: Harvard University Press, 1985) at 4, 187.
the costs of reducing malpractice cease to be less than the costs of malpractice itself. Reductions in the possibility of medical malpractice beyond this point, such as might occur when certain medical procedures are used defensively or purely out of fear of legal liability, are simply not worth their costs.

Second, there are the costs of administering to this goal of an optimally reduced level of medical misadventure. It is also senseless to achieve savings in the combined costs of medical malpractice and malpractice avoidance if the costs of achieving this goal, and maintaining it, are themselves very high. In the current debate about medical malpractice, this concern for the costs of administration manifests itself as a concern about the high costs of litigation, in particular, the high costs of determining medical fault. Even if the fault system finally isolates that standard of medical care that properly balances the possible costs of medical misadventure against the costs of avoiding that misadventure, this achievement can be overshadowed by the high costs of having to adjudicate that standard of care.

In this section and the next, I shall argue that a proper attention to all three types of costs, namely, the costs of medical malpractice occurrences, the costs of avoiding medical malpractice occurrences, and the costs of administration, argues for a system of strict hospital liability. The no fault result is by far the most controversial and radical aspect of my claim and I leave it for separate treatment in section IV. We shall see there that concern for the second and third types of costs are primarily what motivates the strict liability part of my proposal. In this section III, however, it is the first and second types of costs which lie behind targeting the hospital in particular.

A. Reducing the Frequency and Costs of Medical Accidents

1. Targeting the Institution

A harm-based liability rule that is designed to provide incentives to reduce the frequency and, therefore, the costs of accidents must be based on several key assumptions regarding the defendant as the target of liability. First, the defendant must have the capacity to reduce the probability of the accident either by adjusting the level of care or the level of the activity. Adjustments in care take as given that the defendant is engaged in the activity and assume that the activity can be performed more safely so that fewer accidents occur. Adjustments in the level of activity involve reducing the amount of the activity overall so that even if there is no change in how carefully the activity is carried on, there will be fewer accidents as a result. For example, we can reduce the amount of pollution discharge into the air either by installing more pollution abatement devices in our factories (a care level response) or by reducing the number of factories that we have (an activity level response). In the medical context, it is generally easier to think that sensible reductions in the frequency of medical misadventure will come through adjustments in care rather than through reductions in activity levels. It seems more plausible to argue, for example, that appendectomies should be performed more carefully than to argue that fewer appendectomies should be performed. However, in cases where the demand for medical services is more obviously voluntary, such as in cosmetic surgery, or where there are substitute medical procedures that are (arguably) less risky, such as in caesarian section

39 The difference between care level and activity level adjustments to avoid accidents is neatly articulated in A.M. Polinsky, An Introduction to Law and Economics (Toronto: Little, Brown, 1983) at 37-49.

40 I emphasize the word sensible here. Clearly, when physicians, out of fear of malpractice liability, choose not to go into certain specialties (e.g., obstetrics), or choose not to see certain types of patients or to perform certain kinds of high-risk procedures, these are all activity level responses. However, these are usually thought to be the kinds of activity level response we want to avoid. The idea is not to have less medicine because it is dangerous but rather, less dangerous medicine.
deliveries, it is arguable that activity level responses to medical misadventure might be effective.

Second, beyond having the capacity to make some care or activity level response that is effective against accidents, the defendant must also have information that some such response is required. This means that, at a minimum, the defendant must know that something is wrong. In a sense, this is just a reiteration of the point that the defendant must have the capacity to adjust either at the care or activity level. However, an emphasis on the particular question of information forces us to focus on an issue that is particularly relevant to the choice between individual and institutional harm-based liability rules. An individual defendant may only be the cause of an occasional or single, isolated accident. Such occurrences may generate no pattern of misadventure which could possibly suggest to the individual the different kinds of care or reduced levels of overall activity that might be appropriate. An institution employing many such individuals, on the other hand, might be able to see a pattern in what to the individuals involved are isolated occurrences. This pattern of misadventure might argue for some adjustment in the level of the individual's care or activity as mandated by the institution. Thus, even if both individuals and institutions had the capacity to make the requisite adjustments if they knew something was wrong, only institutions might be in a position to see that there is something systematically wrong in the first place.

In addition to spotting systematic (and, therefore, remediable) misadventure, an institution might also have a large enough statistical basis to spot the sorts of adjustments to accidents, either at the care or activity level, that are most appropriate. An individual, on the other hand, even if he or she believes that the isolated accident shows that something is amiss, may have no actuarial basis for

\[41\] Cf. P.A. Bell, "Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability" (1984) 35 Syracuse L. Rev. 939 at 963: "Insurers are certainly correct in recognizing that most doctors do not have enough 'experience' to permit an actuary to predict with any confidence their expected liability costs." Compare also Weiler, supra, note 6 at 145: "[O]ne needs a good deal of experience before one can validly calculate that this particular doctor really is significantly worse than his peers. A sufficient amount of experience is unlikely to be found in suits against individual doctors (as opposed to large organizations, such as hospitals)."
making adjustments away from the status quo in the direction of real improvement.

Of course, the mere mention of an actuarial basis for informed judgments about accidents argues that there is a role for insurance companies and suggests that the distinction between individuals and institutions as targets for liability might be overdrawn. After all, individuals are typically insured for liability, especially in the context of medical malpractice, and surely, insurance companies can generate the requisite information about systematic misadventure from their respective insurance pools. However, this reply ignores the fact that it is better finally to locate the costs of accidents that are systematically occurring not only on that defendant that can appreciate that there is something systematic going on (something which, admittedly, would not distinguish an individual’s insurance company from the individual’s institution) but also, on that defendant which has the technical expertise to make systematic adjustments to set things right. In the complex medical context, it seems plausible to argue that this technical ability will be much required and is more likely to be found within a medical institution than within an insurance company.

A rough test of these arguments for the comparative advantage of institutions over individuals to make the requisite readjustments in the sorts of care they take against accidents can be conducted by looking at how insurance companies price their liability insurance. Presumably, if the companies believed that their different clients could make adjustments in their levels of care, so that there were fewer liability claims, they would provide those clients with the incentives to do so in the liability insurance contract. They would, for example, use deductibles, co-insurance, or individualized experience rating. Such pricing mechanisms are commonplace for individual insureds in the motor vehicle context. However, in the case of physician malpractice insurance, there is little or no such pricing behaviour by the insurance companies or the insurance reciprocals involved.\textsuperscript{42} This suggests that in the

\textsuperscript{42} Bell, supra, note 41 at 962-63. The Introductory Booklet for New Members 1989 of the Canadian Medical Protective Association, the association that provides insurance coverage for the great majority of practicing physicians in Canada, clearly shows that while the Association charges different insurance premia for different categories of physician according
judgment of these insurers, there is little real return to focussing these financial incentives on individual physicians. More likely than not, this is because the sources of iatrogenic injuries are widespread, i.e., the momentary lapses of generally competent doctors operating within a risky environment; therefore, there is nothing to be gained, and much to be lost in administrative expense, in selectively pricing against physicians who happen to have higher than average individual claims experience.

By contrast, insurers of hospitals and other health care institutions do typically experience rate. This is because a hospital or large institution can have a sufficient number of claims to constitute a credible actuarial experience on which to base variations in the price of liability insurance. Thus, in practice the incentives generated by a harm-based liability system are more likely, through the pricing of insurance, to be brought home against health care institutions than they are against individual physicians.

2. What Institution?

A general argument for an institutional rather than individual harm-based liability rule still leaves open what institution should be targeted for liability. Even though some 80 percent of all medical misadventures occur within hospitals, it is not obvious that the hospital corporation itself represents the only real institutional choice for liability. Other institutional possibilities include departments or sections within the hospital (e.g., the anaesthesiology department, the emergency room, etc.) and any coordinated groups of individual

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43 For example, the Hospital Insurance Reciprocal of Ontario (HIRO) typically offers differential insurance premia to individual hospitals according to whether they have a Quality Insurance or Risk Management program in place. I am grateful to David Brisley of the Ontario Hospital Association for providing me with this information about HIRO.

hospital physicians who could be thought of as being in something akin to partnership with one another.\textsuperscript{45}

Such examples of institutional liability might still preserve a sufficiently large statistical basis for systematic judgment on the real sources of some particular kind of iatrogenic injury while at the same time avoiding the problem of bringing liability incentives to bear only upon a large and essentially unresponsive bureaucracy. It is surely arguable that while top hospital administrators might be good fund raisers, lobbyists, and public relations officers for the hospital, they have little or no expertise about medical procedures and the sorts of adjustments that can sensibly be made in particular treatments to avoid the recurrence of medical misadventures. On the other hand, what better informed locus of liability can there be, for example, for the particular difficulties arising in anaesthesiology than the anaesthesiology department, or the group of individual anaesthesiologists working together in the hospital? Such a defendant or group of defendants is "on the scene" in a way that some administrator is not and, further, has the technical expertise to judge the sources of complex medical problems and how they might be remedied.

The problem with these intermediate forms of institutional liability for the acts of individual hospital physicians arises from the fact that the institution, as argued above, needs more than just good statistical information that it is technically competent to judge and react to if it is to be an effective target for liability. In particular, it must also have the capacity, meaning not only the practical ability but also the legal authority, to take action to prevent the conduct that might produce liability. Thus, for example, if the department of anaesthesiology discovers a set of better standards and procedures

\textsuperscript{45} For discussion of this last possibility, see J.F. Horty & D.M. Mulholland, "The Legal Status of the Hospital Medical Staff" (1979) 22 St. Louis U. L.J. 485. In Corleto v. Shore Memorial Hospital, 350 A. 2d 534 (N.J. 1975), plaintiff contended that the physicians on the medical staff could be sued because they constituted an unincorporated association and, therefore, each member of staff was responsible for the acts of the others. On a motion to dismiss, the trial court upheld this contention; however, the plaintiff eventually dropped the action after a settlement was negotiated with the defendant physicians' insurance company. For some general discussion of the liability possibilities in targeting some part of a larger institution rather than the whole institution itself, see C.D. Stone, "Choice of Target and Other Law Enforcement Variables" in M.L. Friedland, ed., Sanctions and Rewards in the Legal System: A Multidisciplinary Approach (Toronto: University of Toronto Press, 1989).
Controlling the Costs of Medical Malpractice

for the care and effective monitoring of patients under anaesthetic, they must be in a position to mandate that these new procedures be adopted and, if necessary, that additional personnel and equipment be acquired to put the procedures into effect. More importantly, the department might also have to be in a position to back up its mandated procedures with threats of dismissal or reduced privileges for those individual members of departmental staff who fail to comply. Typically, departmental chiefs do not now have these powers and, without them, any move towards departmental liability would be without its cutting edge. Usually, individual members of staff, including departmental chiefs, sit on credential and/or medical advisory committees and only have the power to review appointments and make recommendations to the hospital's governing board. At most, hospital by-laws may also provide that a departmental chief can temporarily suspend or vary the privileges of individual members of the medical staff. But the final decision on appointments or re-appointments, and the permanent reduction or termination of particular hospital privileges, remains with the board.

In addition to the problems surrounding a lack of final authority to act against conduct giving rise to liability, there is also the difficulty that these intermediate institutions might not have sufficient incentive to act on their expertise even if they did have that authority. Suppose, for example, that a departmental chief was targeted for personal liability for medical malpractice occurring within her department. It is difficult to believe that she would not insist on the hospital providing some kind of insurance or indemnity for her against personal liability. Such arrangements are common for directors within corporations and are thought to be essential if competent personnel is to be attracted to take on the job. Such arrangements also indicate that the least cost bearer of the risk of liability is ultimately the corporation whatever the initial liability

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47 Ibid.

48 See C.D. Stone's discussion of these arrangements in "The Place of Enterprise Liability in the Control of Corporate Conduct" (1980) 90 Yale L.J. 1 at 45-56.
assignment. However, once hospital corporations and their agents, or departmental chiefs, can reallocate among themselves the ultimate risks of adverse legal judgments, one has to wonder what is gained by targeting some more intermediate level of institutional liability in the first place. Perhaps the better view is to continue to focus the incentives of a harm-based liability rule on the whole hospital and hope that the effect of such liability will be that senior administrators will become more informed (either directly or by constant consultation with departmental chiefs) than they currently are about the systematic medical misadventures that do occur and how best to avoid them. The prevailing view among physicians that senior hospital administrators know very little about the technical aspects of safe health care delivery may simply be a reflection of the fact that without hospital liability for medical misadventure, they have little real incentive to become better informed. Competence tracks liability; indeed, that is the whole point of harm-based liability rules.

So far the discussion has proceeded as if the choice is to find some appropriate institutional defendant which is to be exclusively liable. However, there is a richer array of options if one recognizes that different defendants can be held jointly liable for the same negligently caused injury. Indeed, the usual forms of vicarious liability for employee negligence are of this kind, with the plaintiff able to sue either the employee or the employer in the first instance, and the employer typically in a position to recover from the employee in a subsequent action for indemnity. Variations on the vicarious liability rule include allowing actions for contribution rather than indemnity between the defendants, making only one of the defendants liable to the plaintiff in the first instance but continuing to allow indemnity and/or contribution, making both defendants

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49 This, at least, is what the Coase theorem suggests. See R.H. Coase, "The Problem of Social Cost" (1960) 3 J. Law & Econ. 1. Given costless transactions, the parties will transfer the burden of liability to that party which can bear it most cheaply.

50 The vicarious liability of hospitals, for example, operates this way. See E. Picard, "The Liability of Hospitals in Common Law Canada" (1981) 26 McGill L.J. 997 at 1019.

51 Negligence Act, R.S.O. 1980, c. 315, s. 3.
initially liable but disallowing contribution or indemnity,\textsuperscript{52} or making only one of the defendants liable and disallowing any sort of subsequent action for indemnity and contribution (i.e., a kind of immunity rule for a particular potential defendant). In addition, one can vary the grounds for indemnity or contribution by, for example, limiting them to cases of gross rather than mere negligence.

In section V of the paper, I shall argue that hospital liability should be combined with a physician immunity rule, except in cases of gross physician negligence where I would allow a hospital indemnity action against the physician. This aspect of my overall prescription is motivated by my concerns over the possibility of excessive precautions being taken by physicians to avoid legal liability rather than to provide quality health care, the problem of defensive medicine. It is to a discussion of this important topic which I now turn. As we shall see, the problem of defensive medicine provides further argument for hospital rather than physician liability.

B. The Costs of Precautions: Concerns About Defensive Medicine

In section III.A, I argued that the prospect of harm-based liability is very unlikely to influence, in any sort of productive way, the care level decisions of individual physicians if most iatrogenic injuries, viewed from the physician’s perspective, are unsystematic and reflective only of momentary distractions or lapses in attention to the risks at hand. I suggested that the targeting of institutions, since they are in a better position to aggregate these seemingly isolated occurrences into some overall pattern of avoidable behaviour, is more likely to be conducive to the reduction of medical injuries. In particular, I claimed that institutional liability at the level of the hospital, rather than at some lower institutional level, would generate the incentives to take care at the point where there was also (sensibly) the required authority to act. While this might mean targeting a bureaucratic defendant which is furthest from the complexities of actual on-site health care delivery, I suggested that liability for health care misadventure might be just what is required

\textsuperscript{52} The common law rule in \textit{Merryweather v. Nixan} (1799), 101 E.R. 1337 (K.B.).
to induce these higher levels of hospital administrators to solicit help and information from those individuals (e.g., physicians) with greater technical expertise.

However, while individual physicians might not be able to systematically change their treatments so as to significantly or efficiently reduce the incidence of medical injury, this is not to say that they do not continue to worry, and to worry systematically, about the prospect of legal liability. This, I suggest, influences the way they practice medicine even if it does not productively influence the extent to which they cause injury. At issue here is the problem of wasteful defensive medicine, the sort of medicine that goes to avoiding legal liability rather than providing quality health care.\(^5\)

Estimates of the extent of defensive medicine vary, but a recent estimate in the United States, using two different methodologies, put the 1984 cost of the additional component of medical practice that was due to concerns for tort liability at around $10 billion, or more than three times the total amount that American doctors were paying that year for malpractice premiums.\(^4\)

Now it is a mistake, of course, to straightforwardly use such an estimate as a measure of medicine that has little or no therapeutic value and is only practised out of fear of legal liability.

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\(^5\) The American Medical Association has characterized defensive medicine in the following way (as quoted in L.J. Nelson III, "Medical Malpractice and the Transformation in Health Care Delivery" (1987) 17 Cum. L. Rev. 313 at 338, note 156):

Most defensive medicine – the ordering of additional tests, the performance of additional procedures, the maintenance of additional records – will have some value to the patient. It is not, therefore, unethical. The problem and the waste lie in the fact that these activities are of only marginal value in most cases, not enough to justify the time and expense in a world where resources are limited and expensive. Defensive medicine serves primarily to validate a clinical judgment in which the physician already has adequate confidence.

\(^4\) R.A. Reynolds, J.A. Rizzo & M.L. Gonzalez, "The Cost of Medical Professional Liability" (1987) 257 J.A.M.A. 2776. See also Weiler, supra, note 6 at 157-65. Submissions made to the Joint Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care (Chair: J.R.S. Prichard) suggest that the scope of defensive medicine is likely to be comparable, on a per capita basis, in Canada. See, for example, C.A. Woodward & W. Rosser, "The Impact of Medical/Legal Liability on Patterns of General and Family Practice in Canada" (Submission to the Joint Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care, September 1988).
After all, the whole point of tort liability as a regime of incentives is to induce changes for the better in health care delivery. Thus, without some independent argument or statistic that the $10 billion worth of changes are largely unjustified, it is possible to argue that the figure is as much a measure of the success of the tort system as its failure.\textsuperscript{55}

Nevertheless, without better empirical estimates of the extent of the problem, I hope to provide theoretical reasons for thinking that inefficient defensive medicine is a likely consequence of our current tort regime. Moreover, I shall argue that the problem would be lessened if hospitals, and not individual physicians, were targeted for liability. Thus, the problems of defensive medicine, or the excessive costs of precaution, provide arguments for increasing hospital liability just as much as our concerns for reducing the costs of medical injuries themselves. To make precise the nature of this claim, and my reasons for it, I shall resort to some elementary economic analysis of negligence law.

1. Three Sorts of Negligence Rule

Over the last twenty years, tort doctrines have increasingly been explained and advocated on the basis of an economic model of the deterrent effects of liability judgments.\textsuperscript{56} Defendants are said to be induced to take optimal care if the failure to do so exposes them to liability for damages. Optimal care is defined within the economic theory as that level of precaution which minimizes the sum of accident costs and accident avoidance costs.

Figure 1 depicts this conventional economic approach to accident law geometrically. The marginal benefits of adopting additional precautions to avoid accidents at different levels of precaution are indicated by the curve MB. Thus, the height of the

\textsuperscript{55} This point is recognized by Weiler, \textit{supra}, note 6 at 159 (contrasting our apparently negative concerns over defensive medicine with our positive views about defensive driving); and Bell, \textit{supra}, note 41 at 971 and at 971, note 144.

curve MB at a particular precaution level (measured on the horizontal axis P) is the reduction in expected accident costs, or harm, that would result from a one unit increase in precaution at that level. (The curve slopes downward to the right to reflect decreasing marginal benefits of increased precautions; an additional x-ray may do some good, for example, but not as much good as the first x-ray.) The area under the curve MB between one precaution level and another is the reduction in total expected accident costs caused by the increase in precautions over that interval. For example, if precautions were to increase from $P_1$ to $P^*$, the expected harm would decrease by an amount equal to the sum of the areas $c + d$.

The curve labelled MC represents the marginal costs of taking additional precautions. (This curve has been drawn as flat in Figure 1, indicating a constant marginal cost for all levels of precaution; for example, an additional x-ray costs the same as the first x-ray.) Again, the area under the MC curve between one precaution level and another is the increase in the total cost of additional precautions over that interval.
For the economist, the optimal level of precautions is at $P^*$ where the MB and MC curves intersect. For levels of precaution less than $P^*$, say $P_1$, the marginal benefits of additional precautions are greater than their marginal costs (indicated by the fact that at all these points the MB curve lies about the MC curve); so society would benefit by moving forward towards $P^*$. For levels of precaution greater than $P^*$, say $P_2$, the marginal benefits of additional precautions are less than their marginal costs, and society would correspondingly benefit by moving back to $P^*$.

On the conventional economic theory of negligence, the defendants are said to have breached their duties of care if they adopt a level of precaution less than the optimal standard $P^*$. This much is well settled within the conventional economic theory. However, there is some ambiguity as to what such negligent defendants should be liable for under the theory, an issue that goes to causation.\(^{57}\) Under one approach, a defendant in breach of his duty of care should be liable only for those accident costs that would not have occurred had the defendant adopted the optimal level of precaution $P^*$. This approach might usefully be called the "but for" causation approach.\(^{58}\) Thus, in Figure 1, a defendant at $P_1$ would expect to be liable only for the total accident costs that could have been avoided had the defendant been at $P^*$, or the sum of areas $c + d$. Since this cost is clearly larger than the costs of avoiding these injuries by moving from $P_1$ to $P^*$ (i.e., $c + d$ is larger than $d$, the costs of the additional precautions), such a negligence rule clearly induces the defendant to move to the optimal level of precaution at $P^*$.

There is, however, a second approach to the causation issue which also surfaces within the conventional economic theory. According to this approach, defendants at $P_1$ who fail to adopt the


\(^{58}\) This is Grady's term. See "Negligence," ibid. at, e.g., 804.
optimal standard of care expose themselves to liability for any harm that might result, so long as it is of the same kind that more of the precaution might have prevented. This could be called the "causal-link" approach.\(^59\) Thus, in Figure 1, a defendant at \(P_1\) would be liable not only for \(c + d\) but also for \(e, f,\) and \(g.\) Clearly, this approach to causation and liability will also induce the defendant to operate at the optimal standard of care. By doing so, the defendant has not breached the duty of care and, therefore, any exposure to liability is avoided.

Thus, although the two different approaches to causation have very different consequences for an individual who is negligent, they both create an incentive for an individual to adopt the optimal care standard. Moreover, in a world where the optimal care standard is known with perfect certainty, neither approach induces a defendant to adopt more precautions than those prescribed by the optimal care standard, since to do so is costly and saves the defendant nothing in terms of liability for expected harm.

However, in a world where there is uncertainty about the optimal care standard, in particular, where the potential defendant is unsure \textit{ex ante} about what standard of care will be deemed optimal by the court \textit{ex post}, the two approaches to causation have radically different implications for defendant behaviour. Under the "but for" causation approach, a defendant who operates at \(P_1\) thinking that this lower level of precaution is the optimal care standard can expect to pay \(c + d\) in liability for damages if he or

\(^59\) Again, this is Grady's term. \textit{Ibid.} at, e.g., 805. It might seem that courts are obviously using a moderate version of the "causal link" approach if defendants are held liable for all negligently caused injuries, even if they are only "more probably than not" (i.e., in just over 50 percent of the cases) the cause of plaintiff's injury; see \textit{Blackstock v. Foster}, [1958] S.R. (N.S.W.) 341 (S.C.). However, this is only an evidentiary rule that can be combined with the "but for" causation rule. On this, see Kahan, \textit{supra}, note 57 at 441. If the court knew with certainty that a negligent defendant's conduct did not cause plaintiff's injury, then there would be no liability under this evidentiary rule and "but for" causation. There could be liability, however, under the "causal link" rule. Thus, the "causal link" rule holds the negligent defendant liable if the plaintiff cannot prove actual causation, so long as he can prove on a balance of probabilities that there is a "causal connection between his injury and the respondent's negligence"; see \textit{McGhee v. National Coal Board}, [1972] 3 All E.R. 1008 at 1017, Lord Salmon, cited with approval on this point in \textit{Wisher v. Essex Area Health Authority}, [1988] All E.R. 71 (H.L.). Nelson, \textit{supra}, note 53 at 334 has suggested that recent American medical malpractice cases use the "causal link" rule. See, for example, \textit{Herskovis v. Group Health Cooperative of Puget Sound}, 664 P. 2d 474 (1983).
she is wrong and $P^*$ is truly the optimal standard. Of course, by operating at $P_I$, the defendant saves the costs of additional precautions between $P_I$ and $P^*$. Thus, the net penalty the defendant pays for the error of underestimating $P^*$ at $P_I$ is only $c + d - d$, or $c$. On the other hand, if the defendant overestimates the optimal care standard by an equivalent amount by operating at $P_2$, then the defendant will pay for the costs of additional precautions, $e + f$, and save nothing in terms of liability for expected damages since the defendant would not have been liable for any damages at the optimal standard $P^*$ in any event. Thus, overestimating $P^*$ (at $P_2$) costs the defendant $e + f$, and equivalently underestimating it (at $P_I$) costs $c$. Since $c = e$ (given an equal magnitude of possible error on either side of the optimal care standard), the penalty for overestimating $P^*$ is greater than the penalty for equally underestimating it. Thus, under the "but for" causation approach, we should expect a bias in the direction of under-precaution.

The opposite is true under the "causal link" approach. The effect of holding a negligent defendant liable for all the accidents that result, so long as they are of the same kind that proper precautions could have prevented, is to create a large discontinuity at the optimal care standard in the defendant's expected liability costs. If the defendant overestimates the optimal care standard and operates at $P_2$, the defendant will pay for the additional costs of precautions, $e + f$, that could have been avoided had the defendant known $P^*$ with certainty. On the other hand, if the defendant makes an error of equal magnitude by underestimating the optimal care standard and operates at $P_I$, then the defendant's expected liability is the sum of $c + d + f + g$. Of course, the defendant saves the costs of precautions $d$; so the net penalty for operating at $P_I$ rather than $P^*$ (or the net penalty of underestimating $P^*$) is $c + f + g$. Again, given an equal magnitude of error on either side of the care standard, $c = e$ and, therefore, the penalty for under-precaution exceeds the penalty for equivalent over-precaution by the amount $g$. Thus, under the "causal link" approach, it pays to err on the side of excess care.

Given these two different behavioural implications under the two different approaches to causation within the conventional economic theory, it is obviously important to have some sense of
how the courts actually operate under the rules of negligence. In fact, there is good reason for believing that even when the courts do adopt language that suggests something like an economic approach to negligence, they are generally not proceeding in the way either of the above two conventional analyses suggests. Rather than compare what the defendant did as against some optimal care standard, courts will generally ask whether there was something the defendant could have done to prevent the accident (causation) for which the expected benefits exceeded the costs (breach of duty). While this sounds very much like the conventional economic approach to negligence, Mark Grady has shown that the implications for defendant behaviour in a world of imperfect information about negligence standards are very different. In particular, this third approach, which Grady now calls the "untaken precaution" approach, does not generally induce over- or under-precaution since, unlike for the conventional rules analysed above, the penalties for equivalent errors in estimating the optimal standard of care are symmetric around the standard. Grady's argument for this result will be spelled out in more detail in section III.B.2.

For the moment, however, it is important to recognize that there are three different economic analyses of negligence which generate three very different implications for a defendant's behaviour. Within the conventional economic theory, which compares the defendant's conduct with some optimal standard, the "but for" causation approach systematically induces under-precaution in a world of uncertain standards; the "causal link" approach provides incentives for over-precaution. Grady's "untaken precaution" rule, on the other hand, appears not to generate any such bias at all. Thus, if all other things are equal, it is arguable that Grady's approach is the one that courts should adopt; and if it is the one courts have adopted, as Grady himself suggests, then bias in the level of precaution taken should not be a significant problem. Our system of tort liability would be providing appropriate incentives for the taking of care.

60 See the discussion of cases in "Negligence," supra, note 57 at 821-29.
61 Ibid. at 817-21.
Nevertheless, in section III.B.2, I shall argue that the medical context is different from the general case analysed by Grady. When one looks at the negligence doctrine in this context, there are reasons to believe that the courts do use something like the conventional economic approach rather than Grady’s "untaken precaution" approach. Thus, we should not be complacent about the possibility of systematic bias in the level of precaution taken by medical defendants. Moreover, I shall argue that, contrary to the more general case, the peculiarities of the medical context are such that all three approaches to negligence systematically generate excessive levels of precaution by physician defendants. This, I claim, provides a robust theoretical explanation for defensive medicine. It also argues, I suggest in section III.B.3, for a system of hospital rather than physician liability.

2. The Peculiar Context of Medical Negligence

There are at least two reasons for thinking that in the medical context, the courts are using something akin to the conventional economic approach to negligence, rather than Grady’s "untaken precaution" approach. First, there is the prominent role that is played by medical custom in determining the proper standard of care in medical treatment. In most negligence actions, the court establishes the requisite standard of care for itself and attends to such concerns as the burden of precautions, the seriousness of the injury, and the likelihood of injury (all of which are relevant to notions of economic cost and benefit). However, in medical malpractice, the court typically allows the medical profession to establish, by its own customary practice, the standards against which a defendant’s actions should be judged. This deference to medical custom may just reflect judicial respect for a sister profession. More likely, it indicates a worry that neither judges nor juries are in as good a position as doctors to evaluate what is appropriate conduct

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63 Weiler, supra, note 6 at 23-28.
in a highly specialized and scientific area of expertise.\textsuperscript{64} In any event; by deferring to custom in this manner, the courts are essentially comparing the defendant's conduct with a given exogenously determined standard which they take as optimal. Depending on their approach to causation, one should expect, on the arguments provided above, either under- or over-precaution if there is some uncertainty for the defendant as to exactly what that standard is.

Second, the medical context has often been one where the courts have invoked the doctrine of \textit{res ipsa loquitur} for proof of negligence.\textsuperscript{65} The onus of proof resting on a plaintiff can be onerous, especially in those situations where he or she knows very little about the events leading up to the injury. This will be the case, for example, when medical mishaps occur during surgery and the plaintiff patient is under anaesthetic. Clearly, in such situations, the plaintiff is not in a good position to suggest that some specific untaken precaution, for which the expected benefits exceed the risk, could have prevented the injury, the sort of burden the plaintiff bears under Grady's rule. Rather, the plaintiff will simply assert that, in the usual course of things, the injury would not have occurred. This too is an approach that suggests comparison with some kind of optimal care standard in the manner suggested by the two more conventional economic approaches to negligence.

Thus, the availability of medical custom as a defence and the use of \textit{res ipsa loquitur} as a method of proving negligence suggest that the courts have adopted an approach to medical negligence that allows for systematic bias away from the optimum in the level of precaution taken by defendants. Normally, this bias could be in either direction, depending on the court's approach to causation. Nevertheless, I now want to argue that a further peculiarity of the medical context means that whatever approach to causation is taken,

\textsuperscript{64} Something more than mere scientific expertise is needed to explain the judicial deference to custom in medicine but not in other areas of technical complexity. The point about a sister profession is made by A.M. Linden, "The Negligent Doctor" (1973) 11 Osgoode Hall L.J. 31 at 33. I suggest yet another reason why courts might defer to custom rather than use their own cost-benefit approach at the end of section III.B.3., \textit{infra} at 555.

\textsuperscript{65} See Weiler, supra, note 6 at 28-30 for an account of new developments in the medical context concerning \textit{res ipsa loquitur}. 
a defendant physician's bias will necessarily be in the direction of excessive precautions.\textsuperscript{66} Moreover, I shall also argue that this same bias arises in the medical context under Grady's "untaken precaution" approach. Thus, all three theories of negligence generate excessive precautions. In the medical context, this excess is commonly referred to as defensive medicine.

Consider again Figure 1. Under the "untaken precaution" approach, a defendant is asked whether there was something extra that could have been done to avoid the accident for which the expected benefits exceed the costs. Suppose the defendant was operating at precaution level \( P_1 \). Then the plaintiff can point to any precaution level up to \( P_2 \) and successfully argue that the defendant's failure to adopt that additional precaution was a breach of duty. This is because the area \( c + d + f \) (the additional benefits of moving from \( P_1 \) to \( P_2 \)) is equal to the area \( d + e + f \) (the additional cost of moving from \( P_1 \) to \( P_2 \)); so for any precaution level just infinitesimally smaller than \( P_2 \), the benefits will exceed the costs.

No such argument is available to the plaintiff if the defendant operates at the optimal standard of care \( P^* \). Thus, the defendant has an incentive to adopt the optimal care standard even though the court need never refer to this standard expressly.

Now suppose that it is difficult for the defendant to estimate or predict with certainty what this standard will be. In situations when the defendant must pay for the costs of precautions, the net penalty for being under-cautious at \( P_1 \) is the additional liability that the defendant can expect, \( c + d + f \), less the costs of precautions that the defendant saves, \( d \), that is, \( c + f \). The net penalty for being equivalently over-cautious at \( P_2 \) is just the additional cost of precautions which have no effect on liability, namely, \( e + f \). Since \( c = e \), there is, therefore, the same penalty for the same amount of error in under- and over-precaution. Thus, there is no systematic incentive to take too little or too much care. So far this is simply Grady's argument in favour of the "untaken precaution" rule over the conventional economic approaches based on either "but for" or "causal link" causation.\textsuperscript{67} If this was how things worked in the

\textsuperscript{66} Grady makes this point in "Negligence," supra, note 57 at 823.

\textsuperscript{67} Ibid. at 814-21.
medical context, we would have some reason to feel content about the incentives generated by our tort system.

But now suppose that the defendant can recover the specific costs of additional cost-justified precautions either from the plaintiff (as a customer) or from some third party. The latter sort of recovery would be exemplified either by a physician recovering costs from the government on a fee-for-service basis, or by a physician directly externalising these additional costs to a hospital. Now the penalty for operating at $P_1$ is $c + d + f$ since there is no net saving in the costs of untaken precautions; the defendant would not have paid for those in any event. Moreover, the penalty for operating at $P_2$ is only $e$ since the costs for any additional cost-justified precautions, namely $f$, are recoverable. (These additional precautions are cost-justified in the sense that they generate total benefits $f$ under the curve MB.) Thus, even under the "untaken precaution" approach, if the defendant can recover the costs of additional cost-justified precautions, the defendant will tend to be excessively cautious.

Moreover, under the conventional economic theories of negligence, both approaches to causation, namely, "but for" causation and "causal link" causation, will also imply excessive precautions by the defendant if the defendant can recover the costs of cost-justified precautions from either the plaintiff or some third party. This should not be surprising for "causal link" causation since excessive levels of precautions were already implied by the rule even before the costs of precautions were assumed to be recoverable. What is more surprising is that cost recovery completely reverses the tendency that we observed under "but for" causation for defendants to err on the side of too little caution.

Nevertheless, the incentive to be overly cautious is more circumscribed under "but for" causation than it is under the "untaken precaution" rule. This is because the penalty under "but for" causation for erring on the side of too little precaution at $P_1$ is $c + d$, or the additional expected liability, whereas the penalty for such an error under the "untaken precaution" rule is $c + d + f$. Since the penalty on the side of too much precaution is the same under either rule given cost recovery, the net penalty for under-precaution is greater under the "untaken precaution" rule. Thus, we should expect a correspondingly greater bias in the direction of excess
precautions. This might explain further why the courts, at least in the medical context where physician's costs are either recoverable or capable of being externalised to hospitals, appear to have adopted the conventional economic approach of comparing the defendant's conduct with an optimal care standard.\textsuperscript{68} When combined with "but for" causation, such an approach to the breach of duty question generates the least amount of defensive medicine among all the physician negligence rules. However, as the argument to follow will show, we can do even better than this by targeting the hospital rather than the physician for liability, and by adopting strict liability rather than negligence as our liability standard.

3. Hospital Liability and Defensive Medicine

There are several reasons for thinking that a move from physician to hospital liability might reduce the unambiguous bias towards defensive medicine that we observe under all the physician negligence rules. First, the arguments in section III.B.2 above were based on a defendant's recovery of cost-justified precautions. These arguments do not apply to the extent that hospitals are funded prospectively according to an anticipated patient workload,\textsuperscript{69} and not (subject to difficult re-negotiations in the budget) according to the actual costs incurred for the particular services provided. Thus, we return to the general and varying predictions of the original three economic models of negligence. In particular, under "but for" causation, a defendant hospital would tend to be less than optimally cautious; under "causal link" causation, it would be overly cautious. Grady's "untaken precaution" rule would generate no bias one way or the other.

A second reason for thinking that hospital liability might lead to less bias in the direction of excessive precautions is also related to the hospital's overall budgeting process. A hospital faced with a fixed (or, at least, largely non-renegotiable) budget faces the true

\textsuperscript{68} See \textit{supra}, note 64 and accompanying text.

\textsuperscript{69} This is the Canadian model. See R.G. Evans, \textit{Strained Mercy: The Economics of Canadian Health Care} (Toronto: Butterworths, 1984) at 174-76; and Rachlins & Kushner, \textit{supra}, note 1 at 29.
opportunity costs of any choice to provide additional services for any particular patient. This much follows simply from the fact that the hospital, and not the individual doctor, is the overarching health care provider, attending to many patients and many different demands on its resources. Thus, where a physician calling for an additional test or consultation can externalize the costs of these extra precautions, either to other doctors (where they might still be recoverable) or to the hospital (where, at the margin at least, they are not), the hospital must itself absorb these shifting costs between different individuals or departments. This greater internalization of the costs of defensive medicine tends to reduce their incidence.

Third, and finally, there is the effect of risk aversion. So far, aversion to risk has played no role in the analysis generating the tendency towards excess precautions. A risk neutral defendant under the "causal link" approach to negligence, for example, would still be excessively cautious. This much simply follows from the fact that the expected penalty for error on the side of excess precaution is less than the penalty for equivalent error on the side of too little precaution. If one adds risk aversion to the equation, however, so that the defendant is motivated not just by the magnitude of some expected penalty but also by its variability, then any bias towards over-precaution is further exaggerated and any bias towards under-precaution is attenuated. This is because the costs of underestimating the optimal standard of care is greater liability for damages, which is variable, whereas the costs of overestimating it are the costs of excess precaution, which are (largely) fixed. A risk averse defendant should be more concerned about an equal expected amount of the former than the latter.

There is reason for believing that individual physicians should be more risk averse than hospitals with respect to variable liability for damages. Individuals, who may only face a few instances of litigation in their careers, cannot pool the risks of litigation and thus,

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70 The hospital, therefore, provides us with a version of the "extended firm" solution to externalities. Coase, supra, note 49 canvasses this as one of the possible solutions to externality problems when market transactions are relatively costly.

71 It also provides further argument for internalizing the costs of medical malpractice to the whole hospital corporation rather than sub-units of that institution, the possibility considered in section III.A.2., supra at 539.
cannot reduce the variance in its expected costs. Institutions, on the other hand, can operate much as insurance companies do, aggregating the offsetting or non-correlated risks of the different individuals working for them so that the variance in expected costs of litigation is reduced. Thus, institutions, and in particular hospitals, will be less risk averse than the individuals working in them with respect to possible liability for damages. Thus, they should be less inclined than physicians towards excessive levels of precaution, or in medical parlance, less prone to defensive medicine.

It will be objected, of course, that since both individual physicians and hospitals are typically insured against liability, a difference in risk aversion between the two types of defendant will have little effect. But this ignores the fact that much of the costs of tort litigation is uninsured. For both the physician and the hospital, for example, lost time and lost reputation are also important costs of the litigation process. Without giving some attention to those uninsured costs, it is hard to think why there should be anything like defensive medicine in the first place.

IV. THE ARGUMENT FOR STRICT HOSPITAL LIABILITY

Section III above presented a two-pronged argument for targeting institutions, in particular hospitals, for liability for physician negligence. In section III.A, I suggested on the benefit side that hospitals, unlike individual physicians, would be in a position to discern patterns of injury-causing behaviour and, unlike insurance companies and lower level institutions within the hospital, have the technical expertise, as well as the overall authority, to do something about them. In section III.B, I tried to reinforce this argument on the cost side by suggesting that hospitals would have less of an incentive than individual physicians to engage in the excessive (i.e., largely non-therapeutic or only minimally so) precautions that we commonly refer to as defensive medicine. It now remains to

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72 Bell, supra, note 41 provides a more psychological and less economic account of the deterrent effect of liability judgments in the medical context. Psychological costs are unlikely to be insured. Indeed, that is a point often made by economists; see, e.g., S.A. Rea, "Nonpecuniary Loss and Breach of Contract" (1982) 11 J. Leg. Stud. 35.
consider whether the third sort of cost identified at the beginning of section III, namely, the cost of administering different liability rules, also favours hospital liability and, if it does, what form that liability should take. Not surprisingly, perhaps, this is the point at which we must consider the strict liability alternative. We shall see that not only does a rule of strict liability save on administration costs, but a rule of strict hospital liability in particular is the only such rule that is both cheap to administer and not systematically conducive to bias away from the optimal standard of care.

By now, we have investigated six different possible rules of negligence. There are the three rules of negligence that are identified by the three different economic approaches, namely, "but for" causation, "causal link" causation, and Grady's "untaken precaution" rule; and each of the three can be applied to one of two different defendants, the individual physician or the hospital. I argued in section III.B.2 that all three rules of negligence generate excessive levels of precaution when applied to physician defendants, with "but for" causation being the least costly rule in this respect and "causal link" causation the most costly.

Interestingly, the costs of litigating each of these negligence rules is likely to rank them in the reverse order. Most expensive to litigate is a rule of "but for" causation: Not only must a court determine the optimal care standard and how well the defendant's behaviour compares with the standard, but it also has to determine whether the defendant's breach of the standard was actually the cause of the plaintiff's injury. This is a very particular causal determination. "Causal link" litigation, on the other hand, does much to free itself from judicial determinations of actual cause. Once the court has determined that there has been a breach of the optimal standard of care, the defendant is essentially held strictly liable for all injuries that occur, so long as they are of the kind that could have been avoided by proper precautions.

Grady's "untaken precaution" rule probably stands somewhere in between the above two rules with respect to litigation costs. On the one hand, it should be more expensive under the "untaken precaution" rule than under either of the other two rules to determine whether there has been a breach of duty. This is evident since the courts generally choose to defer to medical custom rather than investigate the standard of care issue themselves; presumably,
the courts do this at least in part because it is easier, or less costly, to leave this matter to the judgment of experts. On the other hand, like the "causal link" rule, which largely avoids issues of causation, the "untaken precaution" rule also economizes significantly on the costs of litigating causation because the plaintiff is free to point to any untaken precaution that could have avoided the accident that occurred. The plaintiff's real difficulty will be in proving that the untaken precaution, which is causally relevant almost by assumption, should have been undertaken on cost-benefit grounds. This is, of course, a breach of duty question. Thus, the "untaken precaution" rule, while it involves relatively expensive judicial determinations as to whether there has been a breach of duty, is relatively cheap (perhaps even as cheap as the "causal link" rule) to litigate vis-à-vis causation. These speculations on the relative rankings of the three physician negligence rules, as they concern both the costs of litigation and the costs of deviations from the optimal standard of care, are summarized at rows 1 to 3 in Table 1.

It is interesting to speculate at this point how these different physician negligence rules might compare with a rule of strict physician liability. It is certainly tempting to think that strict liability would be a cheaper rule to litigate in each individual case. After all, one of the key components of a successful negligence action, breach of duty, is removed as an issue in the determination of strict liability. Thus, strict physician liability should be cheaper than all of the physician negligence rules with respect to the costs of litigating the breach of duty issue. (I indicate as much in the middle column of row 7 in Table 1.)

However, the real problem area for a strict liability rule in the medical context is thought to be causation. Unlike a healthy employee who goes to work or a healthy driver about to get into a car, the patient who comes to a physician is already sick or injured. This prior condition, therefore, may be as much the cause of some subsequent disability as any intervening medical misadventure. This feature of the medical context is said to make any kind of no fault or strict liability regime problematic; it will just be too difficult to

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73 R.E. Keeton, "Compensation for Medical Accidents" (1973) 121 U. Pa. L. Rev. 590 at 614: "Perhaps the most troublesome problem facing those who propose to adopt a nonfault insurance system for medical accidents ... is the causation issue."
disentangle the consequences of medical intervention from the consequences flowing from the original condition which necessitated the intervention in the first place.

Table 1
Costs

<table>
<thead>
<tr>
<th>A. Over/Under-Precaution (e.g., Defensive Medicine)</th>
<th>B. Litigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breach of duty</td>
<td>Causation</td>
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</table>

<table>
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<tr>
<th>Physician Negligence Rules:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) &quot;But for&quot; Causation</td>
<td>a little too much precaution</td>
</tr>
<tr>
<td>(2) &quot;Causal Link&quot; Causation</td>
<td>much too much precaution</td>
</tr>
<tr>
<td>(3) &quot;Untaken Precaution&quot; Rule (Grady)</td>
<td>too much precaution</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Liability for Physician Negligence Rules:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(4) &quot;But for&quot; Causation</td>
<td>too little precaution</td>
</tr>
<tr>
<td>(5) &quot;Causal Link&quot; Causation</td>
<td>too much precaution</td>
</tr>
<tr>
<td>(6) &quot;Untaken Precaution&quot; Rule (Grady)</td>
<td>optimal precaution</td>
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</tbody>
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<tr>
<th>Strict Liability Rules</th>
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<tbody>
<tr>
<td>(7) Strict Physician Liability</td>
<td>too much precaution</td>
</tr>
<tr>
<td>(8) Strict Hospital Liability</td>
<td>optimal precaution</td>
</tr>
</tbody>
</table>

All this may be true, but the real question is whether this sceptical argument serves to disadvantage in any way a regime of strict liability as compared to negligence. After all, if the argument from causation only says that it is difficult in a medical context to determine what consequence flows from the medical intervention as opposed to the patient’s original condition, then this is as much a
difficulty for a negligence action as it is for one based on strict liability. When a negligence action asks whether the injury is the consequence of some physicians's negligent treatment of the patient, a strict liability action asks only whether the injury is the result of that physician's treatment. As already argued, the difference between the two goes to whether or not the court needs to investigate whether the treatment was negligent; but the investigation as to whether medical treatment was even a cause is a feature common to both types of action. Thus, while litigating the causation issue might be expensive under a regime of strict physician liability, it is unlikely, on a case by case basis, to be any cheaper under physician negligence rules. (I represent this conclusion in the last column of Table 1.74)

It will be objected, however, that it is wrong to compare the relative costs of litigation under strict liability and negligence on a case by case basis only. In particular, the claim will be that the real costs of a strict liability regime are to be found in the fact that such a regime generates more litigation even though the costs of litigating each case might be smaller than for negligence.75 After all, where a negligence standard leaves the costs of non-negligent conduct to lie where they fall, a strict liability standard insists on transferring these costs from the plaintiff to the defendant. A proponent of strict liability should be able to show some significant advantage in the move to strict liability if these increased amounts of litigation are to be justified.

One consideration that does not seem to favour strict physician liability over any of the negligence rules is the one that goes to defensive medicine. This should not be surprising. Consider again Figure 1. Suppose a physician could recover all the costs of his or her precautions, but was strictly liable for all of the costs of any misadventure that might occur under treatment regardless of

74 It is, of course, true that if in a negligence action it is certain that there hasn't been a breach of the duty of care, then there is no point to litigating the issue of causation, and the costs of litigating that issue are saved as compared to a strict liability action. (This is essentially the point considered in the next paragraph of the text.) However, negligence cases that are litigated will likely leave no stone unturned and will tend to litigate the causation issue as well as breach of duty.

75 Landes & Posner, supra, note 56 at 64-65 have made this point against strict liability.
fault. Then, surely, the physician would operate at the maximum precaution level $P_x$ in Figure 1, thereby reducing all expected liability to zero and recovering all the costs of precaution. This would be defensive medicine with a vengeance.

However, it is an implausible result. Rather than reimburse a physician for all the costs of any procedure, or even the cost-justified costs of a given procedure, a third party reimburser, such as the government under a social health insurance plan, is likely to make its best estimate of the optimal standard of care at a point beyond which the marginal costs exceed the benefits (i.e., estimate $P^*$ in Figure 1) and fund no additional costs of precautions beyond that point. Then the physician, if able to estimate the marginal cost and benefit curves correctly, will be induced to operate at $P^*$. Any level of precaution beyond $P^*$ exposes the physician to unreimbursed costs which are higher than the expected damages for which the physician is strictly liable.

However, just as for all of the physician negligence rules, we can resurrect the tendency towards defensive medicine if we introduce physician uncertainty about the optimal care standard. If the physician is uncertain about what $P^*$ is, then under strict liability, the cost of underestimating $P^*$ at $P_1$ is just the cost of the additional damages for which the physician will be strictly liable, $c + d$. (There are no precaution cost savings in operating at $P_1$ since those costs would be recoverable from the fee for service re-imburser.) The costs of equally overestimating $P^*$ at $P_2$ is $e$. Thus, the net penalty for underestimating rather than equally overestimating the optimal care standard (given that $c = e$) is $d$. This is the same as the net penalty for underestimating one's appropriate precaution level under Grady's "untaken precaution" rule, and it is larger, and smaller, respectively, than the penalty for such an error under the "but for" causation rule and the "causal link" rule. Thus, where strict physician liability might perform better than a "causal link" physician negligence rule, it still induces excessive levels of defensive medicine, which are at least as high as under Grady's "untaken precaution" rule.

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76 See, for example, the Health Insurance Act, R.S.O. 1980, c. 197, s. 24(3)(c) which allows for a Medical Review Committee to recommend against government reimbursement to physicians for physician services when such services are "not provided in accordance with accepted professional services and practice."
and probably worse than under a "but for" causation rule. It is hard to conclude, therefore, that there is any strong justification for strict liability, at least if it applies only to physicians, to be found here. (I summarize this result in column A of row 7 in Table 1.)

It is now appropriate to consider strict hospital liability for physician conduct leading to medical injury. We have already argued that hospital liability for physician negligence attenuates some of the tendency towards defensive medicine that characterizes all the physician negligence rules. This was because hospitals tended to be less risk averse than physicians with respect to liability, and because hospitals faced a largely fixed budget which forced them to consider overall interdepartmental costs and which, unlike for individual physicians, did not allow piecemeal recovery of fees for additional services from a third party reimburser. Nevertheless, the distorting effects that Grady first pointed out as problematic for the two conventional economic approaches to negligence remained and argued for Grady's "untaken precaution" rule instead. The difficulty with Grady's rule, as Table 1 serves to remind us (column B of row 6), was that it was relatively expensive to litigate. The question remains whether a strict hospital liability rule, while it saves on the administrative expenses of litigation, can also reduce the problem that continues to plague the cheapest to litigate negligence rule based on "causal link" causation, namely the problem of excessive precautions or defensive medicine. If it can, then we will have isolated a rule which is relatively cheap to litigate on a case by case basis and which does not generate excessively costly precautions on the part of defendants. Given the extremely high costs of defensive medicine, the latter form of cost saving would probably more than justify the higher levels of litigation that would ensue under a strict liability regime as compared to negligence.

It does appear that a strict hospital liability rule should have this advantage over a rule providing for hospital liability for physician negligence. Recall that under the conventional economic approach to negligence, there was a distortion in the direction of under-precaution with the "but for" causation rule. The source of this distortion was that the hospital defendant would pay the costs of

77 See text accompanying note 54, supra at 544.
additional precaution beyond the optimal care standard but save nothing on liability as compared to being at the optimal care standard. This would systematically induce error on the side of underestimating the optimal care standard since liability would be limited to those damages for which the breach was a "but for" cause. This penalty is smaller than that involved in equally overestimating the optimal care standard under the rule. Under strict hospital liability, by contrast, the hospital defendant continues to be liable for any damages caused by lack of precaution beyond the optimal care standard. Thus, in contrast to negligence, taking these additional precautions can avoid this extra liability. This induces the hospital defendant to consider, at the margin, the relative costs of taking any additional precautions and the benefits thereby secured in the form of lower expected liability. Thus, the hospital defendant is induced to use its best estimate of the optimal care standard rather than bias itself in favour of under-precaution.

The same kind of argument can be used to show that strict hospital liability avoids the bias that favoured excessive precautions under the "causal link" negligence rule. Recall that under this rule of negligence, the tendency towards excessive precautions arose out of the fact that any errors on the side of under-precaution exposed the defendant to liability for all damages that ensued that were of a kind that additional precautions could have prevented. On the other hand, over-precaution saved the defendant from any liability at all. Again, this is simply the sharp discontinuity in damage liability that characterizes any rule of negligence. Thus, the hospital defendant in a negligence regime was induced to err on the side of excessive precaution. However, under strict liability, the hospital defendant's liability is a continuous function of damages. Thus, erring on the side of excessive precautions, while it saves on the liability costs of damages that are actually avoided, does not save on all liability for damages. Hence, again, the hospital defendant is induced under strict liability to consider, at the margin, all the relative costs and benefits of additional precautions and to operate as near to its best estimate of the optimal care standard as possible. There is no incentive to practice defensive medicine so as to avoid liability.

In summary, of all the eight liability rules canvassed above (namely, the three approaches to negligence each targeting either a
physician or hospital defendant, plus the two strict liability rules aimed at the same two defendants), there are only two that do not introduce some systematic distortion into a defendant's precautionary behaviour. These are the rule of strict hospital liability and the "untaken precaution" rule of hospital liability for physician negligence. However, as evidenced by the judicial deference to medical custom, the latter rule is relatively expensive to litigate since it requires the court to determine on a case by case basis whether there is a specific untaken precaution which could have avoided the medical accident that actually occurred for which the expected benefits exceeded the costs. Strict hospital liability avoids the high costs of litigating such a breach of duty issue while at the same time not adding significantly to the costs of litigating causation. Thus, strict hospital liability is the only liability rule of the eight which is relatively cheap to administer and which avoids systematically biasing a defendant's choice of precaution level. Under strict hospital liability, the defendant always does best to operate at its own best estimate of the optimal standard of care. These different results for the eight liability rules are all presented in summary form in Table 1.

V. AN EXCEPTION TO STRICT HOSPITAL LIABILITY: THE CASE OF GROSS PHYSICIAN NEGLIGENCE

It should be apparent that the combined arguments of sections III and IV are arguments against physician liability as much as they are arguments in favour of hospital liability. This is particularly so because so much of the analysis concerned the problem of defensive medicine, a problem which seemed to be particularly acute under all the physician liability rules. Thus, while the arguments above favour a regime of strict hospital liability, they also argue in general for combining that result with a rule of physician immunity. Thus, physicians should not be considered as joint tortfeasors with hospitals, nor should hospitals generally have rights of indemnity against them. Such add-ons to a regime of strict hospital liability would only resurrect the problems of defensive medicine which strict hospital liability was designed initially to avoid.
Physician immunity from tort liability does not mean, of course, that physicians need not worry about malpractice even if they were so disposed. In particular, under strict hospital liability for medical misadventure, the sanction against the physician for negligent treatment, as for failure to adopt new risk management techniques, is likely to take the form of reduced hospital privileges, or a refusal by the hospital to re-appoint the physician to the hospital staff. In effect, the hospital operates as a kind of gatekeeper, restricting patient access to physicians who are unwilling or unable to meet the required standard of care.78

Loss of hospital privileges, of course, imposes a significant and discontinuous (all or nothing) sanction on physicians, and one might legitimately wonder whether there is not the same danger here, as there was under physician negligence, of overly cautious or defensive behaviour by physicians. However, the difference under strict hospital liability is that the hospital is as much concerned about sanctioning a physician who is overly cautious and prone to take excessive care (and, therefore, expensive for the hospital to have on staff) as it is about a physician who takes too few precautions and exposes the hospital to liability for damages. Thus, the physician's liability to sanction, while admittedly discontinuous in its effect around the hospital's prescribed standard of care, nevertheless operates symmetrically around that standard and, therefore, generates no bias in the physician towards over- or under-precaution.

However, mention of the discontinuous nature of the loss of privileges sanction that hospitals might impose on physicians suggests a specific exception to the general rule of having strict hospital liability combined with physician immunity. Physicians who have little at stake, or little to gain, by failing to follow their hospital's prescribed standard of care will tend to follow that standard rather than risk the high costs of losing their hospital privileges. However, physicians who have much to gain by failing to follow that standard might well be prepared to give up their privileges. Alternatively, we could say that a physician who fails to meet the standard by some

small amount, and, therefore, exposes himself or herself to the hospital’s sanction of lost privileges, might as well go on and secure whatever benefits are thereby secured to a much greater extent by grossly violating the hospital’s standard. Thus, for example, if a physician is performing unnecessary surgery, thereby exposing patients to unnecessary risk and the hospital to unjustifiable expense, the physician might as well do so wantonly, totally, and repeatedly. Under the hospital sanction, it is as cheap for the physician "to be hanged for a sheep as a lamb." 79

This argument suggests that, when they occur in any systematic way, departures by physicians from the hospital’s prescribed standard of care will be gross rather than trivial, and intentional (or, possibly, reckless) rather than merely inadvertent. To prevent this, at least in so far as the problem exists on the side of grossly deficient precautions, it is useful to impose another sanction which varies directly and continuously with the additional expected damages. An indemnity action by the hospital against the physician for the damages flowing from such gross negligence effects just this result. It controls the large and intentional departures from the optimal care standard while not inducing overly cautious defensive medicine in the more usual cases of ordinary negligence.

One might well wonder why the hospital should continue to be liable to the patient at all, if the grossly negligent physician is ultimately going to reimburse the hospital in an indemnity action. Why not have the patient sue the grossly negligent physician directly? The answer lies in appreciating that the hospital is better situated than the patient to judge whether or not the physician is guilty of gross rather than merely ordinary negligence. If the patient had to sue the physician directly in such cases, this information would have to be communicated by the hospital to the patient. Moreover, since it is a way of avoiding hospital liability, the hospital would have an incentive to suggest to every patient who was injured that the physician was grossly negligent. Thus, a direct action by the patient against the grossly negligent physician would necessitate a costly transfer of information from the hospital to the patient in a

79 R.D. Cooter has made a comparable argument to explain the need for punitive damages in tort. See R.D. Cooter, "Economic Analysis of Punitive Damages" (1982) 56 S. Cal. L. Rev. 79.
context where such information lacks credibility. A hospital indemnity action avoids all this by allowing the hospital to act on its own information as it sees fit.  

VI. CONCLUDING REMARKS

While the case of *Yepremian v. Scarborough General Hospital* might suggest that the scope of hospital liability for physician malpractice remains restricted in Canada, the decision to settle that case before the Supreme Court of Canada had occasion to review the matter still leaves our law somewhat unsettled. This paper has argued that there are good reasons for expanding the scope of hospital liability for physician negligence and even for making the liability standard one of strict liability. Except in cases of gross physician negligence, where a hospital indemnity action against the physician should be allowed, strict hospital liability for physician malpractice targets the defendant who is best able to take action to avoid the recurrence of the malpractice, and does so without encouraging overly cautious, and costly, defensive medicine.

Doubtless, a call for strict hospital liability for physician malpractice will appear both radical and impractical. It is radical because it appears to upset our current tort system in two key respects. Not only does it shift liability from the physician to the

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81 However, for the reasons referred to in note 36, such an expansion in the scope of hospital liability should be legislated rather than adjudicated within the confines of a tort action.
82 At this point, one might well ask why, if the proposed hospital liability regime is so advantageous, the parties involved have not seen fit to adopt it themselves by way of some sort of contractual agreement. This is what the Coase theorem suggests should happen; see *supra*, note 49. The answer lies in realizing that the substitution of strict liability for negligence raises the overall costs of medicine, no matter who in particular (physician or hospital) bears the increased burden. Thus, there is no strict liability contract that can be written for these two parties that is advantageous to both of them as compared to the present negligence regime. The proposed strict liability regime is only socially advantageous when all parties are counted in the calculus, including potential patients. But the transactions costs of including potential patients in the contract are obviously prohibitively high. Thus, we should not expect the proposed liability regime to arise contractually. I am grateful to Mark Gillen for encouraging me to consider this point.
hospital, but it also replaces the negligence standard with strict liability. The latter change also suggests why the proposal might be thought impractical. Under negligence, the costs of non-negligently caused medical injuries are borne by the patients who suffer them; under strict liability, these costs are internalized to the health care delivery system. We constantly hear stories that our health care system in general, and our hospitals in particular, are over budget even now under negligence.\(^83\) We might well ask how it can be practical or politically realistic, therefore, to impose further costs on these institutions by moving to strict liability.

However, we should not overemphasize the radical nature of a move to strict liability. Under the current physician negligence regime, we are already whittling away at the fault standard even while we continue to use fault language. Judicial decisions have discarded the locality rule,\(^84\) expanded \textit{res ipsa loquitur},\(^85\) and diluted the cause-in-fact standard.\(^86\) These developments have, unsystematically to be sure, brought us closer to strict liability than our fault language might suggest. A forthright legislative change to strict liability would probably be a less radical change than a superficial analysis of our current law would suggest. When we combine this more sophisticated appreciation of our fault system with the idea in \textit{Yepremian} that vicarious or direct hospital liability for physician malpractice remains unsettled, strict hospital liability also appears to be a less radical proposal.

Nor should we let our concerns for the practical blind us to the fact that the costs of non-negligently caused medical injuries, although not borne by our health care delivery system directly, are nevertheless costs internal to our political system overall. Costs do not go away because someone or some institution in particular does

\(^{83}\) In September 1988, 117 of Ontario's 222 hospitals were operating in deficit. See Rachlis & Kusher, \textit{supra}, note 1 at 30.

\(^{84}\) The "locality rule" (customary medical practice evaluated according to the standards of a very particular geographical area) was largely undermined in \textit{McCormick v. Marcotte} (1971), 20 D.L.R. (3d) 345 at 347 (S.C.C.).

\(^{85}\) The expanded use of \textit{res ipsa loquitur} is more an American than a Canadian phenomenon. See \textit{supra}, note 65.

\(^{86}\) \textit{Supra}, note 59.
not bear them. It is a false economy, out of a concern for practical politics, to resist the move to strict liability just because it allows hospitals to externalize certain costs from their strained budgets to society at large. 87 The more honest approach is to bring these costs into account within the health care delivery system where they belong.

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87 It is, of course, dangerous to use the language of cost externalization. As Coase, supra, note 49 taught us, it takes at least two activities to interact and produce costs in their conflicting desire to use some scarce resource. Thus, these costs are as much the product of any one activity as the other. Moreover, this Coasian insight helps us assess regimes of strict liability. It is sometimes argued, for example, that a standard of strict liability is to be preferred to negligence because strict liability helps to price the liable activity at its true social costs even if those costs are non-negligently incurred. This is to be encouraged, the argument goes, because we want to provide the requisite incentives for individuals to move into safer, or less costly, activities. However, Coase encourages us to recognize that while strict liability for one of the two interacting activities might correctly price that activity, it fails to bring any of the costs of the interaction to bear on the second of the two activities. Thus, there is no incentive to regulate or curtail this latter activity. Some of this problem can be (and commonly is) covered up with a defence of contributory negligence within a strict liability regime, but that only burdens the plaintiff at the care, not the activity, level. There is no way in the context of a tort action (which, in zero sum fashion, only takes from the defendant to give to the plaintiff) simultaneously to burden both the defendant and the plaintiff at the activity level. On this, see Green, "On the Optimal Structure of Liability Laws" (1976) 7 Bell J. Econ. 553; and Shavell, supra, note 56 at 29.

Given the above result on reciprocally interacting activities, the argument for strict liability over negligence reduces to a belief that the defendant is in a better position than the plaintiff to adjust activity level so as to minimize or (at least) reduce the costs of those interactions. In the medical context, I think this is a reasonable assumption. In the extreme, there is little a patient can reasonably do, at either the care or the activity level, to avoid the costs of malpractice in the treatment of acute appendicitis or the delivery of a child. The defendant hospital, however, can effectively research into new medical techniques and adopt safer methods of delivering on the old ones. For a more sceptical view of the possibility of determining which activity to burden with strict liability, see M.J. Trebilcock, "The Social Insurance-Deterrence Dilemma of Modern North American Tort Law: A Canadian Perspective on the Liability Insurance Crisis" (1987) 24 San Diego L. Rev. 929 at 987-88; and also, M.J. Trebilcock, "The Role of Insurance Considerations in the Choice of Efficient Civil Liability Rules" (1988) 4 J. L. Econ. & Organization 243 at 258-63.