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"Law and Medicine: Conflict or Collaboration?"

Cushing Oration

American Association of Neurological Surgeons

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I INTRODUCTION

I have the honour of coming before you as the Cushing orator.

Perhaps it is wishful thinking on my part, but I like to imagine that Harvey Cushing would have accepted your selection of me as the one to deliver this year's Oration. Dr. Cushing took a serious interest in ethical questions. Ethics and law are inextricably bound. Dr. Cushing also worked closely with Sir William Osler, a truly great Canadian. For his biography of Osler, Dr. Cushing won the Pulitzer Prize. Dr. Cushing was a man of wide interests, perhaps even sufficiently wide to tolerate the prospect of a Canadian lawyer giving a lecture dedicated to his memory.

Doctors and lawyers have much in common. We are both members of learned professions with long and proud histories. Both professions have highly developed ethical codes.


Dedication to the welfare of patient or client is our primary guide.

Doctors and lawyers, however, often find themselves in apparent conflict, particularly where a patient seeks compensation from a doctor for alleged negligence or malpractice. The lawyer’s task is to do the best he or she can for the client, and in cases of medical malpractice, this will be at the expense of the doctor.

I would like first of all to focus on this difficult area where conflict between our professions is perhaps more evident than collaboration. I have two principal themes. First, I will contend that, properly understood, the legal rules governing malpractice claims are in truth the product of collaboration between doctors and lawyers. Second, I will attempt to highlight some distinctive features of the Canadian approach.

The Canadian and American legal systems share a great deal, particularly the English common law heritage. But despite our common beginnings, we are distinct societies and our respective legal systems reflect those differences.
I will mention some important systemic and procedural differences which affect the legal climate in Canada. I will also consider the substantive rules of liability. Here, the Canadian and American approaches are similar. Finally, I will outline for you the manner in which our courts calculate the damages payable to an injured plaintiff. There, I believe, the Canadian approach is distinctive.

I would like to conclude my remarks by discussing briefly some of the profoundly difficult medical-legal ethical questions our two professions must confront together in a spirit of complete collaboration.

II SYSTEMIC AND PROCEDURAL DIFFERENCES

(a) Role of the Supreme Court of Canada

When I come to discuss substantive issues, I intend to focus on some of the judgments of the Court on which I sit, the Supreme Court of Canada. I should indicate to you at the outset an important difference between the Canadian and American legal systems. Both countries are federal, in other words, in both responsibility for legislation in relation to particular matters is divided by the constitution between the national and the state or provincial governments. In both
Canada and the United States, the law relating to medical malpractice is a matter of provincial or state legislative concern.

However, legislation on the subject is not all that common and (with the notable exception in Canada of the Quebec Civil Code) rules relating to liability and damages are governed by the common law. By common law I mean the body of legal rules derived from the experience and learning reflected by the decided cases. The American Constitution does not confer upon the United States Supreme Court general appellate jurisdiction and, as I understand it, a medical malpractice case would rarely, if ever, come before your Supreme Court. This means that the various state courts determine through their decisions the shape of the law in medical malpractice and there is no institution at the national level with the capacity to unify the law. The Supreme Court of Canada, on the other hand, is a court of general appellate jurisdiction. We have both the right and the duty to hear cases in all areas of the law. Decisions from our Court on a point of common law on a topic such as medical malpractice will be followed in all the provinces, even though from the legislative viewpoint, medical malpractice is a matter of provincial concern. This may all
seem rather technical, but it is important. As I shall explain, our Court has laid down some very important general common law principles, particularly in relation to "informed consent" and the limit on the amount of damages that may be awarded in a personal injury case. Because of the position of our Court in the Canadian legal hierarchy, those principles will be followed throughout the country, subject to any specific legislative change.

(b) Use of Juries

An important procedural difference between Canada and the United States is the role of the jury. Juries perform a central role in criminal trials in Canada, but are not frequently used in civil suits for damages. Our Constitution guarantees the right to a jury trial, but only in serious criminal cases, unlike the American Constitution which guarantees the right to a jury trial in civil suits as well. In many Canadian provinces, civil cases are never tried by a jury. Even in those jurisdictions where the civil jury is more frequently encountered, the use of juries in medical

3 Charter of Rights and Freedoms, s. 11(f).

4 Seventh Amendment.
malpractice suits is still very much the exception rather than the rule.\textsuperscript{5}

I was a trial judge for several years and have great confidence in the jury system in criminal cases where individual liberty is at stake. I have heard American lawyers express similar views praising the jury in civil suits. I offer no comment on the advantages or disadvantages of juries in civil cases in the United States. I simply say that it is obvious that the use of juries will influence the manner of presentation and the actual determination of liability and damages in medical malpractice suits. The fact that juries are not commonly used in relation to medical malpractice claims in Canada is a significant factor. It has, in my view, facilitated the highly structured analysis of damage issues mandated by decisions of our Court which I will explain in due course.

(c) Cost Rules

Another important procedural difference between Canada and the United States relates to our indemnity for cost rules

or, as it tends to be called in the United States, "fee-shifting". In all Canadian jurisdictions, the normal rule is that the loser in a civil suit must pay a portion of the legal costs of the winner. This imposes a significant downside risk to the potential litigant who is considering suing. If the case fails, the unsuccessful litigant will be faced with a hefty legal bill from his or her opponent. As I understand it, in the United States, "fee-shifting" is the exception rather than the rule.

Moreover, many Canadian jurisdictions either prohibit or limit contingency fee agreements. A contingency fee agreement is an arrangement between a client and a lawyer that the lawyer will not be paid if the suit is unsuccessful, and that if successful, the lawyer will recover a fixed percentage of the damages awarded. The typical American litigant contemplating a malpractice suit will usually be able to retain counsel on a contingency basis and will not

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8 Canadian Civil Procedure, supra, pp. 253-256.
face the risk of having to pay the doctor's legal costs if the claim is rejected. The typical Canadian litigant, on the other hand, must be able to retain a lawyer on a fee for service basis and then must face the risk of having to bear a healthy portion of the doctor's legal bill if the case fails.

Canadian rules of practice also typically permit a defendant in a suit formally to offer the plaintiff a specified sum in settlement of the claim. If the plaintiff rejects that offer and goes on to recover an amount less than the amount the defendant offered, then, even though the suit was successful, the plaintiff must pay the defendant's legal costs incurred after the date the offer was made.\(^9\) These formal settlement procedures are a potent device to discourage suits by litigants who have inflated notions of the value of their claims.

In sum, the Canadian litigant is certainly faced with a much more discouraging set of cost rules. Again, it is not for me to comment on which system is better. There are those who contend that our Canadian rules are too discouraging and

\(^9\) See, e.g. Ontario Rule 49, British Columbia Rule 57(18).
that access to the courts would be improved if they were altered. My point is simply that the economics of litigation in Canada are different from the economics of litigation in the United States and that this may well account for important differences in the behaviour of litigants and the nature of claims which come before the courts in the two countries.

III LIABILITY RULES

(a) Standard of Care

Let me begin by discussing the legal definition of the appropriate standard of care in cases where it is alleged that a physician was negligent in the diagnosis or treatment of a patient.

Legal rules recognize that a doctor cannot guarantee successful treatment. Physicians are not insurers by virtue of the doctor-patient relationship. Medicine is a science, but at the same time, is subject to human contingency. It would be unrealistic and unfair to hold physicians to a

10 For a critical American perspective on some of the rules which exist in Canada, see Fiss, O.M., "Against Settlement" (1984) 93 Yale L.J. 1073.
standard of strict responsibility with liability imposed on a no-fault basis requiring compensation to all plaintiffs for any mis-adventure suffered in the course of medical treatment. Lawyers and judges recognize that medical diagnosis and treatment often call for the exercise of individual judgment. Second-guessing difficult decisions after the fact with the benefit of hind-sight is often invidious.

On the other hand, it is the professional obligation of every doctor to exercise ordinary skill and competence. It is possible to devise an objective list of factors, considerations and procedures which should form the basis of sound medical judgment in any particular case. The physician who fails to follow accepted procedures can fairly be faulted.

In malpractice cases, the courts really do no more than hold physicians to that objective standard. The plaintiff does not succeed upon mere proof of injury or loss. Medical evidence must be called to establish the degree of skill and care reasonably expected of a prudent physician. A mere
error of judgment is not enough. This was explained over thirty years ago in a decision of our Court.\textsuperscript{11}

An error in judgment has long been distinguished from an act of unskillfulness or carelessness or due to lack of knowledge. Although universally-accepted procedures must be observed, they furnish little or no assistance in resolving such a predicament as faced the surgeon here. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation.

In a very real sense, the legal standard of care is that which the medical profession sets for itself. The plaintiff will only succeed if he or she can prove on a balance of probabilities that the defendant failed to live up to the standard of the ordinarily prudent physician. What is reasonably prudent will be established by evidence from other physicians. A specialist will be held to the standards of his or her specialty, and obviously this will be higher than that expected of a general practitioner.

I do not suggest that the standard of care can be determined with mathematical precision. In many cases,

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physicians themselves will differ on what sound practice requires. The important point, however, is that lawyers do not impose an artificial or unrealistic standard upon doctors. The legal standard is derived from what doctors themselves define as appropriate. The standard of care applied in medical malpractice cases is the product of a collaborative effort between the two professions.

(b) **Informed Consent**

There is one category, known to lawyers as the "informed consent" cases, where a physician will be held liable despite having exercised reasonable care and prudence in diagnosis and treatment. I think it fair to say that here the Canadian courts have adopted principles which first evolved in American jurisprudence.\(^\text{12}\) It may seem to physicians that legal rules concerning the patient's right to know intrude unduly in a delicate area of medical judgment. I suggest, however, that the informed consent cases are derived from an ethical principle common to both the medical and legal professions.

The basic principle the courts have enunciated is that every patient has the right to make his or her own decision regarding medical treatment and care. In order to make that decision, the patient is entitled to have full information regarding the material risks of either undergoing or foregoing medical treatment. It is the duty of the physician to supply that information in sufficient detail so that the patient can make an intelligent choice. The physician is, of course, perfectly entitled to make a recommendation urging the patient to accept certain treatment which the physician feels would be in the patient's best interests, but in the end the decision is that of the patient to make.

In my view, the informed consent principle reflects ethical values shared by our two professions. One of my predecessors as Cushing lecturer, Dr. Edmund Pellegrino, explained the importance of according respect to the patient's concept of his own good and the ethics of what he called the Process of Clinical Moral Choice:

A biomedically good decision is one that is scientifically correct, but it is not automatically a good decision from the patient's point of view. It must be placed within the context of the patient's life situation and his value system. It

13 Supra note 1, at 570-571.
must square with what the patient thinks "worthwhile," given the circumstances and choices illness force upon him. Only the patient can weigh the probable medical benefits of a treatment against the pain, disability, and loss of dignity those benefits may "cost" him, or against some ultimate good, such as his concept of his own spiritual destiny.

...Biomedical good and medical indications are, therefore, lowest in the hierarchy of senses in which we can interpret the good of the patient. Beneficial as they might be, they do not justify violation of the higher good of the patient as a human being to express his or her own choices and to determine the specific nature of what is in his "best interests."

...

An assessment of the good to be achieved by a medical intervention should be presented to the patient or his surrogate as sensitively and clearly as possible. It must be fitted to the patient's educational, cultural, linguistic, and ethnic background. The physician has an obligation to assist the patient to make as cogent a choice as possible, and without coercion or deception.

These are precisely the ethical precepts which underlie the legal rules relating to informed consent. The law is really doing nothing more than providing redress to the patient where a fundamental medical-legal ethical principle has not been followed.

Moreover, our courts do not simply hold that failure to inform results in automatic liability. In the leading
Canadian case,¹⁴ our Court rejected a purely subjective approach, in which the plaintiff would recover upon testifying that he would have refused the surgery had he known of the risks. It would be easy to make such statements with the benefit of hindsight, coloured by the bitterness of disappointment resulting from a failed medical procedure.

On the other hand, a purely objective test based solely on medical evidence establishing the reasonableness of a recommended procedure would operate unfairly with respect to patients whose particular needs, interests and feelings would be ignored. In the end, our Court adopted something of a blend of the two. We held that the test was this: what decision would a reasonable person in the patient's position have made? The plaintiff was not entitled to succeed simply upon stating that he would not have chosen surgery. That statement had to be assessed against an objective reasonableness standard. But the particular circumstances in the plaintiff's situation should be taken into account, and where, on the balance of probabilities, a reasonable person in the plaintiff's position fully informed as to the risks,  

¹⁴ Reibl v Hughes, supra
would have opted against a procedure, he or she is entitled to recover.
IV DAMAGES

One of the most difficult tasks facing the judge in a medical malpractice action is the assessment of damages. The basic legal principle is easily stated. The injured plaintiff is entitled to an amount which, so far as money can compensate, will give him or her reparation for the harm suffered. The plaintiff is entitled to be put in the position he or she would have been in but for the defendant's wrong. The award should be based upon a careful assessment of the actual needs and plight of the plaintiff. The purpose of the damage award is to compensate the plaintiff and not to punish the defendant.

The legal principle of fair compensation is easy to understand in the abstract, but not always easy to apply. In a commercial case, this objective is more easily accomplished than in a case involving physical or mental injury. To state in terms of dollars and cents the impact of a physical or mental impairment upon any individual is quite obviously fraught with difficulty. "Money is a barren substitute for health and personal happiness." We are dealing with matters

bound to arouse our sympathy and compassion for the injured party and yet the law requires us to apply objective criteria in a dispassionate way.

Our Court faced these issues in a series of three cases in 1978.\(^{16}\) While none of these was a medical malpractice case, our judgments, collectively known to Canadian lawyers as "the trilogy", attempted to formulate general principles applicable to the assessment of damages in all personal injury cases, including those involving claims against physicians.

Our essential aim in the "trilogy" was to develop a structured and disciplined approach in this difficult area. We held that the plaintiff's actual situation should be considered in detail, item by item. We strove to develop a set of rules which would focus directly on the specific needs of the plaintiff to ensure fair compensation. At the same time, justice required that we ensure defendants have to bear only legitimate and justified claims and that factors such as the defendant's ability to pay would neither escalate nor diminish the amount injured parties received. The over-all

objective was to provide the plaintiff with the money required to live his or her life in relative comfort and dignity. The guiding principle stated by the Court in 1978 is one to which I believe physicians would readily subscribe:17

The current enlightened concept is to dignify the gravely injured person as a continuing, useful member of the human race, to whom every assistance should be afforded with a view to his re-integration into society.

(a) Lump-Sum Awards

The first hurdle we faced was the common law rule that such damages must be assessed in a once-and-for-all lump-sum award. Common law rules do not permit the court to award damages on a "wait and see" basis. There is no mechanism for periodic payments. The court is faced with the invidious task of having to predict the effect the injury will have for the rest of the plaintiff's life. This is truly gazing into the crystal ball. The difficulty is particularly acute in cases where there is a continuing need for expensive care and a long-term loss of earning capacity. After the judgment has been given, the plaintiff's needs may well change. The plaintiff's condition may change for the better or for the

worse. The court is powerless to increase the award of the plaintiff whose illness worsens or to decrease damages where the plaintiff makes an unexpected recovery or even where the plaintiff dies prematurely of some unforeseen cause. Heavy reliance must be placed on long-term medical prognosis and actuarial predictions of life span and earning capacity. We concluded, however, that if the law was to be changed, legislative action was required and that the courts were powerless to do anything to remedy this situation:¹⁸

In spite of the severe difficulties with the present law of personal injury compensation, the positive administrative machinery required for a system of reviewable periodic payments, and the need to hear all interested parties in order to fashion a more enlightened system, both dictate that the appropriate body to act must be the legislature, rather than the courts. Until such time as the legislature acts, the courts must proceed on established principles to award damages which compensate accident victims with justice and humanity for the losses they may suffer.

(b) **Pecuniary Loss**

Damages for personal injuries fall into two categories. First is pecuniary loss, comprised of all actual out-of-pocket expenses for care, treatment and loss of income,
together with an award for projected future costs of care and prospective loss of earnings. In the second category are so-called "non-pecuniary" losses, conventionally awarded to compensate for loss of amenities and enjoyment of life, pain and suffering, and loss of expectation of life.

The first category, pecuniary loss, requires the court to assess the amount of money needed to compensate the plaintiff for the actual loss and expense incurred as the result of the defendant's wrong.

(i) **Cost of Future Care**

In Canada, most medical and hospital costs are covered by government medicare insurance. Defendants who are held liable still must bear the cost of medical care for the insurer is entitled to assert what is known as a subrogated claim in the name of the injured plaintiff against the defendant to recover in full the cost of medical and hospital care.

Past medical expenses are readily calculable. Future costs are determined on the basis of expert medical evidence as to the prognosis and needs of the plaintiff.
A difficult and controversial issue is the determination of the appropriate standard of care. Our Court faced this question in the "trilogy". In one case,\textsuperscript{19} that of a child who suffered devastating physical and mental injury, home care appeared to be the only acceptable possibility. In two of the cases, the plaintiffs had suffered catastrophic physical injuries, requiring permanent round-the-clock care. They had been rendered quadriplegics as a result of an accident. One was unimpaired mentally and was fully aware of his situation and surroundings. The advantages of home care were emotional and psychological.\textsuperscript{20} In the other case, there was evidence that the plaintiff's life span would be shorter unless he received special home care.\textsuperscript{21} The cost of home care in both cases was said to be more than four times that of institutional care. The difference in the quality of life these individuals would have at home was demonstrably superior to that available in an institution. We held that they were not required to mitigate their damages by accepting

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  \item[\textsuperscript{19}] Arnold v. Teno, supra.
  \item[\textsuperscript{20}] Andrews v. Grand & Toy Alberta Ltd., supra.
  \item[\textsuperscript{21}] Thornton v. School District No. 57, supra.
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a less expensive, but inferior type of care. The fair compensation principle required that they receive awards measured by the cost of home care despite the extra expense. We expressly stated that this did not mean that compensation for the cost of home care would be called for in all cases, as the situation could be different in the case of an immobile quadriplegic or severe mental impairment.\textsuperscript{22}

To calculate the cost of future care, it is necessary to consider the plaintiff's life expectancy, determined on the basis of medical and actuarial evidence. It is felt, however, that the plaintiff would be over-compensated if the annual cost of future care were simply multiplied by the number of years of life expectancy, for there are many contingencies and hazards which could well shorten the period for which care is required. As we noted in the "trilogy":\textsuperscript{23}

This whole question of contingencies is fraught with difficulty, for it is in large measure purely speculation. It is a small element of the illogical practice of awarding lump-sum payments for expenses and losses projected to continue over long periods of time. To vary an award by the value of the chance certain contingencies may occur is to assure

\textsuperscript{22} [1978] 2 S.C.R. at 246.

\textsuperscript{23} [1978] 2 S.C.R. at 249-250.
either over-compensation or under-compensation, depending on whether or not the event occurs.

In those cases, we upheld the trial judge's discount for contingencies in the amount of twenty per cent for the adult plaintiffs and ten percent for the infant plaintiff.

(ii) **Loss of Earnings**

Determining prospective loss of earnings calls for the judge to "gaze more deeply into the crystal ball".\(^{24}\) The basic approach is to treat loss of earning capacity as a capital asset which has been lost and which must be valued. Evidence must be called on the career prospects of the plaintiff before and after the incident giving rise to the claim. What would have been the level of earnings? For how long would the plaintiff have worked?

In two of the cases, there was some employment history upon which to base this calculation. In the third, involving a child aged four and a half at the time of the accident, projecting lost earnings was particularly difficult. We

settled on an amount half-way between the "poverty line" and the actual present income of the child's parent.\textsuperscript{25}

Once again, the calculation cannot be on the basis simply of multiplying years times projected income. Contingencies such as unemployment, illness, accident and business depression are all taken into account, although we stressed the need for actuarial evidence to minimize some of the raw guess-work.

As we are required to make a lump sum award, pecuniary losses have to be capitalized. In order to derive an appropriate sum, a self-diminishing fund which will produce the required monthly income over the period of the plaintiff's expected life, the judge has to predict both a likely rate of return, and the impact of future inflation. After considering evidence on both points, the judge determines an appropriate "discount" or "capitalization" rate. On the basis of the evidence available to us in 1978 in the "trilogy", we concluded that a seven percent capitalization rate was appropriate. In some jurisdictions,

\textsuperscript{25} \textbf{Arnold v. Teno, supra.}
the "discount rate" has been determined by legislation so that evidence on the point is not required.\textsuperscript{26}

To avoid over-compensation, it is necessary to reduce the award for loss of earnings to the extent that the future care award would relieve the plaintiff of the burden of many basic living costs.

**Non-Pecuniary Loss**

The most notable feature of the "trilogy" was our approach to non-pecuniary losses. How does one translate in money terms loss of amenities and enjoyment of life, pain and suffering and the loss of expectation of life? We described the problem in the following terms:\textsuperscript{27}

There is no medium of exchange for happiness. There is no market for expectation of life. The monetary evaluation of non-pecuniary losses is a philosophical and policy exercise more than a legal or logical one. The award must be fair and reasonable, fairness being gauged by earlier decisions; but the award must also of necessity be arbitrary or conventional.

\textsuperscript{26} See, e.g. Ontario Rule 53.09, setting a rate of 2 1/2 per cent.

\textsuperscript{27} [1978] 2 S.C.R. at 261.
The absence of an objective standard against which these losses may be measured creates a substantial risk that extravagant claims will be made and in some cases awarded. It may come as no surprise to you that Canadian lawyers and judges find awards for non-pecuniary losses made by many American courts to be excessive. We had the American situation very much in mind in 1978 when we took a distinctly different approach.\textsuperscript{28}

As I have already explained, our Court attempted to give full compensation to the plaintiff for actual and expected pecuniary loss. Where there was a choice to be made between more expensive home care and cheaper institutional care, we held that the fair compensation principle required the more expensive home care. That award was designed to make the life of the injured plaintiff more endurable. While the calculation of future costs for medical expenses and future loss of income was not easy, it was clearly more manageable and more readily disciplined than assessment of non-pecuniary losses. We felt that adherence to the compensation principle

\textsuperscript{28} See especially Arnold v. Teno, supra at 332-3 per Spence J.: "The very real and serious social burden of these exorbitant awards has been illustrated graphically in the United States in cases concerning medical malpractice."
which underlies damage awards called for emphasis to be placed on the pecuniary aspect of damage awards.

As the Court explained in a decision three years after the trilogy:

Pain and suffering and loss of amenities are intangibles. They are not possessions that have an objective, ascertainable value. Professor Kahn-Freund in his brilliant essay "Expectation of Happiness" (1941), 5 Modern L. Rev. 81 [at p. 86], cites the example of the Stoic philosopher Poseidonios, who, when tormented by pain, is reported to have exclaimed: "Pain, thou shalt not defeat me. I shall never admit that thou art an evil." However, Professor Kahn-Freund asks, could we award damages for pain and suffering to this philosopher who welcomed his misery as a test of his own power to resist it? Is the Stoic entitled to less compensation than the weak-willed person who recoils at the slightest suggestion of pain or unhappiness? These examples only reinforce the conclusion that it is fruitless to attempt to put a dollar value on the loss of a faculty in the way that we put a dollar value on the loss of a piece of property.

We rejected the idea that the gravity of the injury should determine the size of the award for non-pecuniary loss, and held that the determining factor was the amount

required to create a fund which could provide for lost amenities:  

Money is awarded because it will serve a useful function in making up for what has been lost in the only way possible, accepting that what has been lost is incapable of being replaced in any direct way.

The purpose of the non-pecuniary award is not really compensatory, but rather to substitute something else for that which cannot be replaced. All of this led us to conclude that an upper limit or cap on such awards was called for. We held that the upper limit for non-pecuniary loss, save in exceptional circumstances, be one hundred thousand 1978 dollars. We felt that limit was just to plaintiffs who had already received full recovery for their pecuniary losses. At the same time, defendants who had already been called upon to bear the full costs of their negligent acts were assured that they would not be faced with exorbitant and wholly unpredictable awards for non-pecuniary losses:


31 Ibid.
If damages for non-pecuniary loss are viewed from a functional perspective, it is reasonable that large amounts should not be awarded once a person is properly provided for in terms of future care of his injuries and disabilities. The money for future care is to provide physical arrangements for assistance, equipment and facilities directly related to the injuries. Additional money to make life more endurable should then be seen as providing more general physical arrangements above and beyond those relating directly to the injuries. The result is a coordinated and interlocking basis for compensation, and a more rational justification for non-pecuniary loss compensation.

V MEDICAL - LEGAL ETHICAL CHALLENGES

As doctors roll back the frontiers of medical knowledge, issues of profound difficulty in ethics and in law are confronted. Here doctors and lawyers must collaborate. Human experimentation, treatment of the hopelessly deformed and terminally ill, euthanasia, abortion, and genetic engineering are all matters which transcend the limits of medicine or law alone.

To the lay-person, advances in medical science are astounding. In vitro fertilization has apparently become a routine procedure. This technique brings the happiness of parenthood to many couples otherwise unable to produce children. But it also gives rise to moral and ethical issues of some complexity, particularly with respect to the use of
embryos said to be "surplus" in the sense that they are fertilized but not implanted. Implantation of human embryos from one woman to another also satisfies the wishes of many couples to have children of their own, but at the same time, one encounters ethical and legal complications with respect to payment and parental rights.

For some, interference with many aspects of the process of contraception, foetal development and birth, is morally unacceptable. They contend the law should reflect and enforce that moral judgment. Others focus on the profoundly personal element and suggest that the law should intrude as little as possible into these sensitive areas of moral choice.

Transplantation of organs from severely deformed and terminally ill new-born infants lacking outer brain development makes life possible for the organ recipient. But this new technique gives rise to complex questions. How does one determine that the donor, who lacks normal
brain function, is dead? Can the concept of "brain death" be used? Is it acceptable to prolong the life of the donor beyond the ordinary requirement of therapy simply in order to use organs for transplant?

Genetic engineering to some conjures up the horrors of an attempt to create a master race, while others see the technique as vital to the attainment of purely therapeutic goals.

Our inability to cope with fatal diseases gives rise to a host of legal and ethical issues. The problem of deciding when it becomes inappropriate to continue treatment will be one familiar to all of you. As medical advances make it possible to sustain vital functions longer and longer, the dimension of the ethical issue increases. In another area, the devastating effects of Acquired Immune Deficiency Syndrome give rise to a list of moral, ethical and legal problems far too long to mention here.

It is certainly easier to list the problems than to suggest answers. Scientific advances are rapid and breathtaking. Moral and ethical judgments are agonizingly difficult. We have reached a point where our capacity to do
seems to have exceeded our capacity to decide what ought to be done. The reach of science is seemingly beyond the grasp of ethics. If we cannot develop a consensus on the moral question, what role should the law play?
I offer no answers to these difficult questions. But one thing is absolutely clear. We must work together, doctors and lawyers, and bring to bear the respective insights of our training and experience in a spirit of cooperation and collaboration.

VI CONCLUSION

Doctors and lawyers share the common goal of the pursuit of the welfare of the patient and client. I have argued that even where litigation brings physicians into conflict with the law, collaboration must be our guide. The standard of care is defined by reference to the expertise of the medical profession. The need for informed consent is based upon the moral and ethical values our professions share. In assessing fair compensation, legal rules are shaped by the need to make the lives of the injured and disabled bearable, again an ethical value we hold in common.

The nature of our day-to-day tasks and the methods we employ may be different, but we must never lose sight of the
fact that the interests of society can only be met if we work closely together.