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PREFACE

The Resource Services Program of the Institute on Human Values in Medicine serves health professional schools through visits and conferences. Visits to individual schools bring a team of three-four persons experienced in human values work to a campus for a two day visit. The Resource Services team may be used to help a new program determine the most appropriate forms of development, aid a fledgling program in assessing its resources for further maturation, or provide outside evaluation for the more established program.

The Conference activities of the Institute have involved persons from about 120 schools and institutions. Some conferences have centered on the general human values activities that can be developed within schools while others have focused on particular themes. The UCLA Conference reported on in this volume is one of fourteen conferences which the Institute has sponsored. The Institute gratefully acknowledges the work of William Winslade and Bernard Towers who conceived of this project, guided it through a successful meeting, and compiled this report of the conference. The Institute also wishes to thank the following organizations for co-sponsorship of this event: The California Medical Education and Research Foundation, the University of Southern California, Office of Health Affairs; and the University of California, Los Angeles School of Medicine.

Edmund D. Pellegrino, M.D.
Director of the Institute
In the Code of Hammurabi (about 4000 years ago) there are several laws governing malpractice. For example, "If a physician operates on a man for a severe wound with a bronze lancet and cause the man's death ... they shall cut off his fingers." The fact that malpractice is still a pervasive and nettlesome, if less gruesome, subject indicates that the problem is neither new nor readily resolved.

There have been fluctuations in the relative importance assigned to the roles of the State and medical educators in protecting the public from medical error. Depending upon social, political, professional and scientific conditions at different times in our own American history, physicians have been trusted more or less by the laity and by lawmakers, and there has been greater or lesser reliance upon peer-reviewed schools of medicine to assure the quality of medical practice. The current wave of more zealous legal restraints and penalties upon both doctors and medical schools arrives, ironically, along with the greatest advances in the sciences cognate to medicine.

The almost infinitely variable and complex relationships between doctors and the sick or injured, from clear emergencies to grey zones of deliberate judgment, make the doctor's ability and conscience the decisive factors in quality assurance. Laws and litigation are no doubt factors which influence all human behavior, including medical practice. But no physician who has weighed genuine dilemmas in the still watches of the night, nor patient who has survived the long ordeal of a grave illness, can doubt the paramount importance of the character of the individual physician in protecting the patient's welfare.

Certainly medical educators bear a heavy responsibility in this sphere. There have been fluctuations, again, in the assignment of such responsibilities by society. Today it is difficult for us to comprehend that as recently as 1774 Adam Smith, one of the towering academic figures in eighteenth century England, actually contested William Cullen's powerful protest against the "selling" of medical degrees by the University of Glasgow! If the obligations of the medical schools are now more universally accepted, however, they are also far more complicated. It is therefore important that medical education and its relation to malpractice action be continuously examined as dispassionately as possible. Sincere dialogue among medical educators, doctors, lawyers and other scholars concerned with this growing social problem seems to me more promising than the emotional reactions which too often claim the limelight.

The Conference here recorded was an earnest effort to resort to reason in a field charged with spite and misunderstanding at least since the days of King Hammurabi.

September, 1977
The volatile political debates in 1975 and 1976 about medical malpractice centered largely upon medical malpractice insurance rates, tort law doctrines and practices, and professional responsibilities of physicians and attorneys. Much discussion, both rhetorical and rational, took place about short term and long term solutions to the numerous interconnected problems. Laws were passed, study commissions were formed, papers were written, government agencies were restructured and, though the political controversy has since diminished, many problems remain unresolved.

Some important issues were not even formulated, much less given serious consideration in professional or academic communities. One such neglected issue - the relationship between medical education and malpractice litigation - gives rise to several related questions: Do current practices in medical education contribute to medical malpractice? If so, what reforms are needed to improve medical education? Even if medical education is not a significant contributing factor to the rise in malpractice litigation, to what extent has the latter influenced the former? What are the possible effects on the physician-patient relationship as a result of the increasing risk of malpractice litigation? In what ways should medical educators address these issues?

To analyze conceptual foundations, to examine value assumptions, formulate empirical hypotheses, and to explore practical implications of such questions, a conference was held on Medical Education and Malpractice Litigation at the University of California, Los Angeles, in early 1976. Co-sponsors of the conference were the Institute on Human Values in Medicine, the California Medical Education and Research Foundation, the University of Southern California Office of Health Affairs and the University of California, Los Angeles School of Medicine. This volume consists of an edited version of the proceedings of the conference.

The formal papers of George L. Engel and Charles E. Lewis were circulated in advance to all participants, in order both to encourage more active and informed discussion and to permit the speakers to elaborate on important points with the help of visual demonstrations (which are not reproduced in this volume). The formal papers and the commentaries of Samuel I. Shuman and Patricia Munch are reproduced here with only minor editorial revision. The additional material introduced by Dr. Lewis at the conference as well as the responses of Ralph Gampell and Joseph Boyle were summarized by the editors. The comments of Joel F. Henning were revised by Mr. Henning for inclusion in this volume. Although other issues of importance arose in the formal and informal discussions, the nature of medical education was the unifying theme of this conference. Accordingly, we have selectively summarized only the content of discussions most pertinent to medical education.
SECTION I

THE BIOMEDICAL MODEL

AND

MEDICAL MALPRACTICE
THE BIOMEDICAL MODEL
AND MEDICAL MALPRACTICE*

George L. Engel, M.D.

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New York, is the author of 250 publications in psychosomatic medicine,
internal medicine, electroencephalography, clinical neurology, psychiatry,
psychoanalysis, and medical education.

*This study was supported by grants from the United States Public Health
Service (USPHS) MH 14151 and MH 11668 and the San Francisco Foundation.
Dr. Engel is a Career Research Awardee at the USPHS.
My motivation for participating in this conference derives not from a particular interest in malpractice per se but from my basic commitment as an educator to the goal of achieving an educational system that graduates physicians capable of providing the highest level of both personal and technical care for their patients. The best assurance against professional liability is a physician who is professionally competent and a patient who is satisfied with the care he or she receives. To approximate such an ideal, professional competence must encompass a sound scientific understanding not only of the somatic processes involved in disease and its treatment but also of the psychosocial processes involved in the sick person's experiences of illness and patienthood.

In this essay I shall argue that, while medical education has grown increasingly proficient in conveying to physicians sophisticated scientific knowledge and technical skills about the body and its aberrations, it has failed to give corresponding attention to the scientific understanding of human behavior and the psychological and social aspects of illness and patient care. The results have been overvaluation of technology, diagnostic overkill, rising incidence of iatrogenic illness, a widening gap between patient and physician, and a growing dissatisfaction among patients, all conducive to increased medical professional liability. (Towers, 1971). The average physician completes his formal education with impressive capabilities to deal with the more technical aspects of bodily disease, but when it comes to dealing with the human side of illness and patient care, he graduates with little more than the native ability and personal qualities with which he entered medical school. The considerable body of knowledge that has accumulated since the turn of the century about human behavior and how this may be applied to achieve more effective patient care and health maintenance remains largely unknown to him. In my judgment neglect of this important dimension of the physician's education lies at the root of the frequently voiced complaints by patients that physicians are insensitive, callous, neglectful, arrogant, and mechanical in their approaches.

There undoubtedly are many reasons for this situation, but the most important, and the one we shall concentrate on, is the pervasive influence of the biomedical model of disease. The philosophic origins of this model have been traced back three or four centuries when established Christian orthodoxy relented to permit dissection of the human body. Such a concession was in keeping with the Christian view of the body as a weak and imperfect vessel for the spirit as long as those allowed access to it did not presume to deal with man's soul, morals, mind, and behavior. This compact helped determine the largely anatomical and structural base upon which modern Western medicine was to be built. (Rasmussen, 1975). The present-day biomedical model begins with cellular pathology, as enunciated by Virchow in 1855, and the germ theory that evolved soon thereafter. As a scientific model, that is, a shared set of assumptions and rules of conduct based on the scientific method and utilized to investigate and explain natural phenomena, the biomedical model was constructed as a framework to elaborate the disordered bodily mechanisms involved in
disease. In its present and purist reductionistic form it holds that all aspects of disease ultimately are to be understood in physicochemical terms and be accessible to treatment by specific physicochemical methods.

To the extent that the model has been used as a basis for the study of structure and function of the body, its successes have far exceeded the most optimistic hopes of its originators, resulting in a diagnostic and therapeutic arsenal undreamed of a century ago. But two undesirable consequences have flowed from its very successes. First, scientific attention has been deflected away from the human, psychosocial aspects of health and disease, and second, as cultural and religious biases against study of human behavior began to recede, the assumption was made that such phenomena too could be reduced to physicochemical processes. In this development the biomedical model has been transformed by its exponents into a general theory capable of explaining all phenomena of life, the unmistakable sign of the decay of a scientific model into a dogma. Present-day proponents, justifiably proud of its successes, now ascribe to it explanatory powers that are patently unjustified. And when they encounter phenomena not readily approachable by physicochemical techniques, they explain them away by saying either that they are beyond the reach of science or are of such complexity that their elucidation must await technologic developments still in the future. Thus, mental activity and social behavior are deemed worthy of consideration only to the extent that they can be approached through study of biochemical events in the brain. The biomedical reductionist does not recognize that social and psychological phenomena reflect different levels of organization of life processes or that each level requires its own unique system of notation and frame of reference for scientific study. Rather, he deals with such frames of reference as mere labels that will be dispensed with once the molecular events he believes to underly the phenomenon in question have been elucidated. Memory, anger, social attachment, love, nurturance, trust, fantasy, pain, worry, grief, creativity, dissatisfaction, maybe even litigation, are each dealt with as though ultimately reducible to molecular events. Hence they require no system of scientific study in their own right. The words "basic," "scientific," and "laboratory" have been preempted by biomedical reductionists to apply only to the study of somatic processes. Only what can be weighed or measured qualifies as properly scientific. All else is designated as "soft" or dismissed as "art." (Even that term is misused. According to the dictionary "art" refers to "skill in doing anything as the result of knowledge or practice" or "a system of rules serving to facilitate the carrying out of certain principles," e.g., scientific. [Oxford English Dictionary].) Thus, data that are derived from direct observation of patients or are psychological or behavioral in nature are considered not amenable to rigorous scientific evaluation. What patients have to report and what the physician can observe with his own senses, regardless of its importance, is given little credence as compared to what can be established through laboratory procedures and sophisticated instrumentation. Small wonder that many medical students are being awarded their degrees without ever having been supervised in the complete interview and physical examination of even a single patient! Small wonder the excessive and inappropriate "shotgun" use of the laboratory with its corresponding discomfort and cost to patients
and increased risk of mishap and malpractice actions! Small wonder that patients feel used, abused, and dehumanised and become resentful of physicians and the system that subjects them to such experiences! Small wonder that many physicians feel bewildered, inept, frustrated, and angry when their sophisticated instrumentation fails to yield the answer and their patients persist in feeling ill and making demands in the face of laboratory demonstration of "no disease"! These are but a few of the penalties we are paying for tolerating the degradation of a productive scientific model into dogma. Paradoxically, some of the most ardent devotees of biomedical science are themselves unwittingly fostering the current antiscientific and anti-intellectual movement, for by denying to fields other than their own the relevance and applicability of the scientific method, they place science and humanism in opposition and the study of human events beyond the reach of science.

As public dissatisfaction with the quality of medical care has once again become more vocal and articulate, thoughtful physicians have begun to question why our present medical educational system is failing in its objectives. For it is clear that even patients with ready access to care complain about the quality of care provided by physicians and medical institutions. But so far the main response from the leaders of American medicine has been a curiously regressive romanticism. Writer after writer pays homage to the triumphs of biomedical science and urges no compromise in the scientific preparation of the future doctor, but few seem to recognize that a major part of the students' scientific education, namely that concerned with the human dimensions of illness, has been largely, if not totally, neglected. (Engel, 1973) Their failure to appreciate this fact is consistent with their blind devotion to the infallibility of biomedical dogma and its denial of the applicability of the scientific method to such matters. One eminent spokesman boasts, "I am in no sense a scientist and have spent my entire professional life as a clinician." He apparently finds it not illogical to propose that while disease "is to be understood in scientific (that is to say, objective, quantitative, reproducible) terms, illness is ultimately to be understood not in scientific, but in humanistic terms." (Barondess, 1974) Once committed to such a position, such reductionist reformers seem to have no alternative other than to urge a return to the past. They believe that merely by exposing students earlier to practitioners caring for patients, preferably away from the hospital setting, the physician of tomorrow not only will escape the dehumanizing influence of "science" but also will acquire the human skills and capabilities of the general practitioner of old. The necessity to develop scientific principles and apply the scientific method to the human dimensions of medicine is simply ignored. The picture conjured up is a blending of the scientific competence of today's physician with the warmth and compassion of yesterday's practitioner.

Unfortunately this simple solution is devoid of logic. Furthermore, there is no historical support for the notion that physicians of past generations were more endowed with compassion and concern than are physicians of today. Indeed, all the available evidence from writings of and about physicians indicates a very different state of affairs. Almost
as far back as one can go, one finds physicians accused of insensitivity and ineptness in their personal dealings with patients and of excessive zeal in their application of whatever therapeutic measures -- however harsh, painful, ill-founded, and dangerous -- happened to fit the prevailing medical systems of their era. DuWors reminds us that in The Canterbury Tales Chaucer first praises a doctor's technical competence, then berates him for his lack of spirituality, for his kickbacks from a pharmacist, and for his love of money (1966). In the early years of this country, when the science of the era promoted bleeding, purging, blistering, cupping, leeching, sweating, and other heroic measures, there was a wide-spread unwillingness of the public to use the services of orthodox doctors. (Stevens, 1971) Homeopathic physicians were particularly popular because, while their diluted therapies did not help, at least they were gentler and did far less harm. (James, 1970) Certainly since the beginnings of scientific medicine a century or more ago the complaints and the solutions have been the same as we hear today. Then as now the cry was that medicine had become too mechanical (scientific) and physicians too money minded; the solution proposed: a nostalgic return to the good old days when doctors were more personally concerned with their patients. Listen to Robert Beal writing in 1882:

"The amenities of professional intercourse, and the obligations of medical men towards each other and the public, were perhaps better observed in 1850 than now. Then the doctor, next to the minister, was the trusted counsellor of every family to whom he ministered. He shared their joys, soothed their sorrows, and every passing year added to and cemented the attachment and affection between them. Now the doctor is regarded more in the light of a tradesman or mechanic, and employed from the same consideration that a grocer, tailor, or shoemaker is. The strong ties of gratitude and affection have almost ceased to exist. Relationship is now placed upon a mere commercial basis, and for that the profession is more to blame than the public."

The same theme is repeated over and over again, always with the assumption that mere exposure to or exhortation from an idealized older physician will serve to inculcate better attitudes and result in more effective practices. Of course it did not then and will not now. For no matter how inspiring a personal example a physician may set for his students, without a scientific understanding of human behavior he will be severely hampered in his ability to communicate principles upon which others can build. More than a century ago Sir William Gull recognized this when he urged upon the profession the need for scientific attention to the psychological side of medicine. In 1870 he wrote:

"The distinction of medicine, as a study, lies in its comprehensiveness. The student of physical science admits that he has to deal with but one half of that truth which is expressed in man. The student of medicine cannot so limit himself. The facts of sensation, whether pleasurable or painful, the influence of the mental emotions, whether exciting or depressing, the dominion of the conscience, approving or disapproving, are for him facts due to the operation of laws into which he must inquire from the point of view which the student of medicine occupies."
These higher facts of man's nature are essentially part of one law, and control and modify human existence equally with lower conditions with which physics alone is concerned. To hold the mind in an equal balance as it passes from the contemplation of the lower facts of our existence to those which characterize the highest claims of our humanity, so as neither to degrade the one nor neglect the other, is one of our highest attainments.

In another address in 1870 he stressed the multiplicity of factors, "the air we breathe, the water we drink, the food we eat, the mechanical accidents to which we are subject, and the varied operations of the senses," which determine how "our bodily structure [is] formed and maintained" and "our mental state is thereby developed." He urged that to master these, "the students' training of today must at every step be directed by the light and checks of science." He warned against exclusive preoccupation with technical details: "If medical education had for its end only mechanical operations, I grant it would not require more than a technical acquaintance with details; but neither medicine nor surgery is a mechanical art." In truly prophetic words Gull wrote in 1868: "[Clinical work] is elucidated by the light of physics, chemistry, and physiology, yet is not comprehended by them as they now stand. In ages gone by Hippocrates had to insulate the study of disease from the inroads of superstition; at the present day we have to guard against assaults on the side of science, and need to watch lest we betray it by accepting a too chemical or physical limit to our thoughts." I read this as a warning against the reductionism which dominates medical thinking of today.

Gull's wise words were ignored then and are ignored now, if they are known at all. But that should not be the case with the counsel of Francis Peabody, whose 1927 paper, "The Care of the Patient," is widely quoted these days, especially by those most concerned about the "dehumanization" of medicine. Who is not familiar with his famous aphorisms, "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient"? And, "The treatment of disease may be entirely impersonal; the care of the patient must be completely personal." Peabody, like others before him, took note of the fact that the graduates of the early 1900's were being charged with being too "scientific" and not knowing how to take care of patients. "The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine—or, to put it more bluntly, they are too 'scientific' and do not know how to take care of patients." These words are now being seized upon by modern critics as a clarion call for more emphasis on the "art" of medicine and a return to the sensitivity and compassion alleged to have characterized the physicians of our fathers' day. Ironically, the physicians of our fathers' day are the very ones who were criticized as too scientific in Peabody's time. A newly appointed dean of a distinguished medical school recently reiterated this theme as follows: "A common indictment of the medical graduate today is that
he knows too much science and too little about the art and practice of medicine. I was amused [sic] recently to note that this is not a new problem." After quoting Peabody, he offers the following suggestions: "I am not sure how much of the art of medicine can be taught, but certainly the student can be exposed to the best of primary care." (Ross, 1975) He too makes the dubious assumption that mere exposure to practicing doctors will accomplish what centuries of experience has shown cannot be accomplished. For without a scientific preparation in the psychosocial aspects of illness and patient care, the products of this new primary-care approach will be no more skillful and effective in their human interactions with patients than were Gull's and Peabody's contemporaries, whose education by today's standards, incidentally, would be regarded as mainly practical not "scientific."

The irony of this dean's statement is that Peabody's message, like Gull's, is totally different from what he implies it to have been. Like others who quote Peabody, he could not have grasped the full meaning of Peabody's paper, for if he had he would be considering quite a different revision for the present rigid biomedical curriculum of his school. Like Gull before him, Peabody rejected the charge that the physician has become "too scientific." On the contrary, he asked, "[Is he] perhaps not scientific enough? The popular conception of a scientist as a man who works in a laboratory and who uses instruments of precision is as inaccurate as it is superficial, for a scientist is known, not by his technical processes, but by his intellectual processes; and the essence of the scientific method of thought is that one proceeds in an orderly manner toward the establishment of a truth." To leave no doubt that he advocated application of the scientific method to the psychological and social as well as the somatic dimensions of illness and patient care, Peabody used clinical examples that illustrated the deleterious consequences of neglect of such issues. He closes by saying, "Thus, the physician who attempts to take care of a patient while he neglects this factor [the emotional life] is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment." (Peabody, 1927)

Gull, Peabody, and others over the past 100 years delineated clearly enough the requirements for a proper education of physicians. They all stressed the indispensability of science and the scientific method for the mastery of the fundamental tasks of the physician and they conceded no differences in the applicability of science to the more human, psychosocial as compared with the somatic, molecular dimensions of illness. And contrary to its critics of today, the Flexner Report of 1910 on medical education, which galvanized the great reforms that took place in the next few years, adhered to exactly such principles. For Flexner also saw no incompatibility between science and practice:

"The conservative in medical education makes much of what he conceives to be a fundamental opposition between medical practice and medical science ... [But] is there any logical incompatibility between the science and the practice of medicine?
"The main intellectual tool of the investigator is the working hypothesis. The scientist is confronted by a definite situation; he observes it for the purpose of taking in all the facts. These suggest to him a line of action. He constructs a hypothesis. Upon this he acts, and the practical outcome of his procedure refutes, confirms or modifies his theory. Between theory and fact his mind flies like a shuttle; and theory is helpful and important just to the degree in which it enables him to understand, relate and control phenomena.

"This is essentially the technique of research: wherein is it irrelevant to bedside practice? The physician, too, is confronted by a definite situation. He must seize its details, and only powers of observation trained in actual experimentation will enable him to do so. The patient's history, conditions, symptoms, form his data. Thereupon he, too, frames his working hypothesis, now called a diagnosis. It suggests a line of action. Is he right or wrong? Has he actually amassed all the significant facts? Does his working hypothesis properly put them together? The sick man's progress is nature's comment and criticism. The professional competency of the physician is in proportion to his ability to heed the response which nature makes to his ministrations. The progress of science and the scientific and intelligent practice of medicine employ, therefore, exactly the same technique." (Flexner, 1910; pp. 54-55)

Flexner's efforts, of course, were aimed primarily at substituting the scientific method for the empiricism that dominated his day. He strongly recommended that the student begin his medical education with devotion to the laboratory sciences as the best means of achieving this. But as we look back over the sixty-five years since the Flexner Report, it is interesting to note how the interpretation of his recommendations became narrowed as the biomedical model became biomedical dogma. Present-day self-styled reformists (Flexner would have called them conservatives) attack the Flexner curriculum for its sharp division into two years of laboratory work followed by two years of clinical work. But it was not Flexner but the biomedical reductionists who effected that rigidification of his proposal. The Flexner division was between the normal and the abnormal on the one hand and the treatment of disease and care of patients on the other. Certainly the normal and abnormal was not meant to exclude people and patients. And while he used the terms "laboratory" and "hospital" to differentiate the two settings, he was very explicit to add, "but the distinction is only superficial, for the hospital is itself the fullest sense a laboratory." And though he specified that the first two years were to be devoted "mainly" to the laboratory sciences of anatomy, physiology, biochemistry, pharmacology, pathology, and bacteriology, he also recommended the inclusion in these years of an introduction to the techniques of clinical data collection, then called physical diagnosis. Throughout, his emphasis was on the thorough indoctrination of the student in the application of the scientific method to all the material pertaining to medicine and patient care. For Flexner "the laboratory" meant any setting in which scientific work can be carried out; it has been the biomedical reductionists who have narrowed the concept to the bench laboratory.
When Flexner wrote his report in the early part of the century, a scientific approach to psychological and social phenomena was only beginning to emerge, the relevance of which he must already have dimly appreciated when he warned that "when the professional training of the physician is once securely established on a scientific basis..., the social role of the physician will generally expand and to support such expansion he will crave a more liberal and disinterested education." Certainly he reveals in this statement his recognition that medicine, as a human caring function, depends upon relationships and a supporting social structure. And obviously he knew that the primary data which the physician utilizes to develop his hypotheses are behavioral, psychological, and social in nature. For what brings a patient to the doctor is discomfort, suffering, and disruption of behavior. These are manifested by verbalizations about internal states, by interferences in physiologic and social functioning, and by changes in appearance and demeanor that the patient does not understand and that he cannot alleviate by his own efforts. (Fabrega, 1976) The physician initiates his investigation with the patient's verbal report of these experiences, to which he adds his own observations of the patient's behavior and physical state. From these he attempts to construct a plausible hypothesis as to the nature of the underlying and contributing physical, psychological, and social processes. For the patient the paramount consideration is that the physician provide relief of suffering. From the physician he expects professional competence and personal interest, and his confidence in the physician and satisfaction with the care provided ultimately depend on the degree to which he feels assured of the doctor's competence and interest.

Flexner, delineating the application of the scientific method to practice, required that the physician demonstrate that he "actually [has] properly amassed all the significant facts" and that "his working hypothesis [has] properly put them all together." "The professional competency of the physician," he notes, "is in proportion to his ability to heed the response which nature makes to his ministrations." Thus, clearly critical for each step of the scientific study and care of the patient is the capability of the physician to create the optimal conditions under which the necessary information may be elicited from and observations made of the patient as diagnostic and therapeutic procedures are carried forth. But these conditions, too, can be defined only in social and psychological terms. For to carry out his job the physician must be concerned with such issues as emotions, personality, human relationships, communication, psychologic defences, coping, cognitive style, language, ethnic and cultural background, and the like. The major techniques for clinical data collection, the interview, observation of behavior, and the physical examination, and the ongoing processes of treatment and care are all carried out within the framework of human relationships and are dependent upon the natural laws that regulate communication and the processing of information, social roles, and how people relate with one another. Yet little of this type of knowledge has been included in any systematic fashion in the education of the physician. As a result of this gap in skill and knowledge physicians tend selectively to focus on and give priority to what seems consistent with the more familiar biomedical model and often in the process overlook what in fact may be the more salient and serious problems for the patient.
Let me illustrate this with some simple but commonplace examples.

Case 1. A 45-year-old woman filed a complaint with the grievance committee of her local medical society, saying that the specialist she consulted about back pain was rude, demeaning, and did not allow her to talk. In his defense the physician submitted a photocopy of his office note in which he recorded his annoyance that the patient "couldn't give a simple answer to a simple question." The quality of the patient's letter made it clear that the woman had good intelligence and command of language. When she became upset and tearful upon being sharply directed to "stick to the facts," she was told she was being too emotional.

Comment. This physician was operating on the basis of a commonly held but invalid notion of the interview as a simple question-answer process, a mechanical model in which the desired information exists in a preformed state, like information stored in a computer. In this model the patient is dealt with as a passive instrument expected to respond predictably to the stimulus of the specific question. This question-answer approach, often geared to elicit yes or no answers, yields notoriously unreliable and incomplete data.

The next case illustrates disregard for the most elemental principles of interviewing and communication necessary to assure maximum reliability of data, a sine qua non of the scientific method.

Case 2. A 17-year-old boy presented himself to the Emergency Department with the complaint "I spit up blood." The house officer substituted the verb "cough" for "spit" and pursued his inquiry accordingly. His admitting note listed the symptom as "hemoptysis." The patient was thereafter referred to as "a 17-year-old boy with hemoptysis" and subjected to the usual work-up for hemoptysis, including bronchoscopy and biopsy of a "suspicious" area, all with negative outcome. I saw the patient on teaching rounds on the seventh hospital day. As is my practice, I asked that no information about the patient or his hospital course be provided any of us until after the patient had been interviewed in the presence of the group by a student who also was seeing him for the first time. (Engel, 1971) More adequately trained in interview technique than the house officer, the student did not neglect to maximize reliability by requiring the patient to explain what he meant by "spit up blood." Further interview then quickly clarified that the bleeding could have had its origin nowhere else than from the posterior nasopharynx, a fact readily verified in the Emergency Department on the next occasion of bleeding.

Comment. Reported in this fashion, it is difficult to see how anyone could fail to appreciate the necessity to clarify the meaning of poorly defined, colloquial, or idiosyncratic patient complaints, much less how such could represent one of the most common interview errors committed by physicians. (Wiener and Nathanson, 1976) Even more disturbing was the attending physician's acceptance, without verification, of the
resident's designation of the complaint as "hemoptysis" and his acquiescence to the totally unnecessary diagnostic study with all its attendant risks. Actually such performance accords with biomedical dogma, which makes little provision for the application of the scientific method to data not measurable in physicochemical terms. Hence, what patients have to say is designated "subjective" and intrinsically unreliable, while what is measured in the laboratory is considered "objective" and highly reliable. Virtually lost has been the principle, so well enunciated by Flexner, which demands tests of reliability for all data, regardless of source. When the house officer gratuitously assumed "spitting up blood" was "hemoptysis" without an attempt at clarification and moved directly to a more or less standardized sequence of diagnostic tests, he in effect bypassed the scientific method and embraced empiricism. In so doing he followed generally acceptable practices, a seemingly paradoxical but actually logical outcome of the narrowing of the concept of science by biomedical dogma.

The next case provides an illustration of how inadequate appreciation by the doctor of the significance of the nonverbal components of interpersonal communication can disrupt the relationship and the subsequent course of medical care. The physician left the bedside of this patient confident that he had given her effective reassurance whereas she felt only more confused, discouraged, and frustrated. As in the previous example, the physician acted on the basis of inadequate information, this time about the woman's psychological needs and social situation. He further compounded his mistake by not recognizing the nonverbal signs that were negating her verbal acquiescence with what he was saying.

Case 3. A middle-aged woman with a past history of intermittent drinking and fatty liver had been abstemious and feeling relatively well until six weeks before admission, when she developed anorexia, fatigue, weakness, and loss of pep and interest. Her physician concurred with her concern that perhaps her liver trouble had flared up and admitted her to the hospital for liver studies, including biopsy. All the laboratory findings were unremarkable and the doctor was now coming to report the biopsy findings. As we walked to the bedside together he gave me a thumbnail sketch of the case and added, "I am sure she will be glad to know the results of the liver biopsy." He greeted her with a cheerful smile and wave of his hand, saying, "Good news, Mrs. Jones, the biopsy shows just a little fat in the liver. So you can leave the hospital in the morning. I'm sure you'll be glad to get home to your family." The patient smiled faintly but said nothing as the doctor began efficiently to palpate her abdomen while asking, "And how are you today?" After momentary hesitation she responded rather wanly, "Pretty good, I guess," but at the same time frowned slightly and raised and let fall her right hand in the gesture of helplessness (Engel, 1974). "Good," he said, "I'm glad to hear that," and walked out of the room with a smile. The patient looked so disconsolate that I lingered behind, commenting, "You don't seem so happy about this." She burst into tears.
Comment. This patient had used the complaint, liver trouble, as a ticket for readmission to the health care system, a common ruse to gain acceptance by the physician who is primarily oriented toward physical problems. (Satin M., 1971, 1972; Waller & Levitt, 1972) In this case, it turned out, her illness had begun when her husband left her for a younger woman. Actually, symptoms were consistent with either or both of at least two hypotheses, liver disease and depression. Her biomedically oriented physician was comfortable with the first but not the second hypothesis and he acted out his discomfort by avoiding altogether consideration of psychosocial issues as possible contributing factors. He effectively blocked the patient from communicating and then ignored the evidence in the form of gestures and facial expressions that the line of action he had adopted was inappropriate and unhelpful. The result, a dissatisfied, resentful, discouraged patient subjected to unnecessary risk, again a consequence of failure to adhere to the scientific method.

Informed consent and patient education are subjects of considerable controversy these days. The next case demonstrates how inadequate understanding of the psychological processes involved in dealing with emotionally disturbing information and the necessity to monitor its progress resulted in a family's being unnecessarily burdened with upsetting misinformation for eighteen months without the doctor's realizing it.

Case 4. A specialist was justifiably proud of the adjustment of a 40-year-old man who had been successfully maintained at home for eighteen months on a new artificial support system. He assured me that the patient and his family had made a remarkable adjustment, and indeed in many respects they had. While my colleague was examining his patient I asked the wife how things were going. She told me of the role reversal, her husband now staying home to care for the children while she went to work, and how difficult it was for him to deal with this. But most distressing of all was to accept the fact that they both knew he had only six more months to live. Tears came to her eyes. They had not yet told the children. On further inquiry she said that the doctor had explained to them that patients on this device survived no more than two years. This exchange took five minutes. I asked about this. He was puzzled and distressed that they should be suffering such a misapprehension, since these were not the facts and he could not remember ever having said anything that could be so construed. Indeed, his concern preoccupied him for the rest of the rounds, but finally he recalled what in fact had been said. In explaining to the family the newness and experimental nature of the procedure, reference was made to the fact that the longest time any patient had so far utilized the system at home was two years. In the course of digesting this complex information both husband and wife had interpreted that to mean that no patient had survived more than two years.

Comment. Here the physician could not be faulted for this misinterpretation by the family, for it is commonplace for people not to be able to assimilate correctly and all at once such complex and disturbing information. What the example does suggest, however, is a discrepancy in his ability to monitor the course of the psychological and social responses
to the treatment procedure as compared to the admirable precision with which he followed the metabolic balance. While every metabolic deflection was promptly detected and adjusted, personal and psychological data were dealt with superficially, incompletely, and inexactly with consequences and implications for the patient and his family far more extensive than this little vignette portrays. Again the problem can be traced to absence of a scientific approach to the psychosocial dimensions of illness and health care.

The examples selected obviously are oversimplified and indeed may inadvertently convey a deceptively simple view of the tasks facing medical education. They are intended not as documentation but merely as illustrations of some of the consequences of neglect of a scientific approach to the psychosocial. They hardly touch upon the subtleties, complexities, and often irrationalities of the many psychological and social issues about which physicians must be more knowledgeable if they are to provide health care that is both scientifically sound and personally satisfying for their patients. For in respect to malpractice we surely can agree that complaints are brought not by satisfied patients, but by those who are angry, frustrated, or disappointed and who feel, rightly or wrongly, that they have been injured through some act of omission or commission by the physician. Doctors who are ignorant and inept in the psychosocial sphere not only are likely to have less appreciation of the multiple variables affecting dissatisfaction and fewer resources to optimize satisfaction; they also are more prone to make diagnostic errors and to resort to procedures and treatments that in themselves increase the risk of injury, as the cases illustrated. Furthermore, they themselves are more likely to be dissatisfied, bored and frustrated, especially with that sizable group of patients for whose care their training did not adequately qualify them. This may be reflected in hostile, rejecting attitudes toward such patients, often contemptuously referred to as "crots" or "turkeys," who day after day confront them with their professional inadequacies. Such attitudes encourage overuse of medications and tests, unconsciously predispose to error, and promote the practice of so called "defensive medicine," which in fact may increase rather than avoid risk. Recently one of my patients came to the surgical clinic for a minor elective procedure under local anesthesia. She was under the customary nothing-by-mouth after 11 P.M. restriction, but on the way to the hospital sucked on a Breath-o-mint because her mouth was dry and she was concerned about breath odor. When the anesthetist learned of this he angrily accused her of disobeying orders and refused to proceed until she signed another release. Then, because her husband is a lawyer, he informed her that he was going to protect himself against possible suit by giving her saline by intravenous drip and oxygen by nasal catheter, both totally unnecessary procedures. The patient was upset by all of this but submitted in silence. However, when, during the brief and altogether painless procedure, he continued to criticize patients who disobey and to blame lawyers for the malpractice mess, she became angry, flushed, and nauseated, her vision blurred, and she felt as though she would pass out. Upon completion of the operation she was weak and trembling and developed a severe throbbing headache. Her anger and headache persisted without abatement until the second day when she "accidently" spilled boiling water on the bandaged hand, suffering thereby a second-degree burn which
necessitated return to the surgeon. To him she exploded in tears about
the anesthetist, whereupon the headache subsided. This of course is a
grotesque caricature of defensive medicine, but it does dramatize its
risks in the hands of those insensitive to the psychological determinants
of patient satisfaction.

In the present atmosphere of crisis, physicians (sometimes a bit
self-righteously) feel themselves the aggrieved party, blaming the ingrati-
tude and ignorance of patients, the venality of lawyers, and the commer-
cialism of the insurance companies. Of course there is nothing new about
this situation; it has been going on for centuries. That it is so resist-
ant to change reflects the unequal power relationship between physician
and patient. It is the physician who holds the superordinate position.
Indeed, the status of patienthood, involving as it does dependence on
the physician for relief of distress, which the patient himself does not
understand or cannot resolve, virtually obliges patients to endow their
physicians with capabilities and qualities that they do not necessarily
possess. Hence from time immemorial patients not only have accepted but
even have been satisfied with dubious if not downright hazardous treat-
ment practices simply because no other option was open to them and the
treatments conformed with the medical knowledge and standards generally
exercised at the time. Thus the paradox exists that neither the success
and standing of the physician in the community nor the satisfaction of
his patients with the care they receive necessarily corresponds with
the scientific soundness of the physician's practices and procedures.
The physician, deluded by the professional status accorded him by his
peers and by the adulation of his patients, all too readily succumbs
to the comforting belief that he is better qualified than the facts ac-
tually justify. He can all too easily ascribe his deficiencies to the
state of the art, since the customary rewards for competence and success
are generously bestowed on other physicians no better endowed than he.
This has been especially so in respect to deficiencies in psychosocial
skills and knowledge since his education has encouraged the notion
that these are intuitively grasped, not based on scientific principles,
and can be learned only empirically. And while many physicians will
acknowledge a need to know more about psychiatry in its more limited
meaning, it is the exceptional physician who will concede that he has
anything to learn about such matters as interviewing, the dynamics of
the doctor-patient relationship, the placebo effect, the psychological
and social determinants of patient compliance, the doctor's counseling
and educational role, the nature of psychological stress, and the role
of psychological factors in inducing illness or facilitating recovery.

Hence it may well be that the present insurance crisis is a blessing
in disguise. For if patient dissatisfaction is a valid index of the risk
of professional liability, then maybe the need to do something about the
problem will compel physicians and medical educators to correct some of
the more obvious causes traceable to defects in their basic education.
The courts define the duty of the physician toward the patient as follows:

"The physician is required to possess that degree of
knowledge and skill, and to exercise that degree of care,
judgment, and skill, which other physicians of good standing
... usually exercise in the same localities under like or
similar circumstances" (Morris and Moritz, 1971)

I would like to think that someday in the not too distant future
sufficiently clear principles and practices will have emerged so that
injury suffered as the result of psychological ignorance and ineptitude
will evoke the same disapprobation as is the case now with surgical and
physical mishaps. This is not to open a Pandora's box of new malpractice
opportunities, but to invoke moral, societal, and legal constraints
against poor practices as another means of overcoming the resistance to
elevating the present low educational standards. For the current situation
is not so different from the days when surgeons ridiculed the concept of
antisepsis and persisted in performing surgery in their frocked coats,
sometimes defiantly sharpening their scalpels on the soles of their shoes
to show their contempt for the power of the invisible germs. Some behav­
iors of contemporary physicians are no less reproachable, if not actually
as hazardous for their patients in terms not only of emotional suffering
but also of physical injury, illness, and even death. And some physicians
are no less stubborn in denying and resisting the need for change. Perhaps
this conference will be a step forward in initiating such reforms.
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COMMENTS ON DR. GEORGE L. ENGEL'S PAPER:

The Biomedical Model

and

Medical Malpractice

Samuel I. Shuman, Ph.D., J.D.

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Dr. Engel's suggestions make so much good sense that it may seem inappropriate for me to make any critical comments at all. However, it is just because his basic thesis is so attractive that I believe it worthwhile to examine carefully and critically even its details. Furthermore, as I shall try to show, it is not in the grand design, but in the specifics of application, where we shall encounter serious questions concerning the pragmatic consequences of Dr. Engel's thesis with regard to medical malpractice and malpractice litigation.

Dr. Engel's basic thesis is that "while medical education has grown increasingly proficient in conveying to physicians sophisticated scientific and technical skills about the body and its aberrations, it has failed to give corresponding attention to the scientific understanding of human behavior and the psychological and social aspects of illness and patient care" (5).* He attributes both the success and failure of current medical education to the "pervasive influence of the biomedical model of disease" (5). He argues that in "its present and purist reductionistic form the biomedical model holds that all aspects of disease ultimately are to be understood in physicochemical terms and be accessible to treatment by specific physicochemical methods" (6). According to Dr. Engel the biomedical model has become a dogma for those whom he labels biomedical reductionists because they do "not recognize that social and psychological phenomena reflect different levels of organizations of life process or that each level requires its own unique system of notation and frame of reference of scientific study.... Memory, anger,...love...are each dealt with as though ultimately reducible to molecular events. Hence they require no system of scientific study in their own right" (6). It is because of this biomedical dogma foisted upon the medical schools by the biological reductionists that the medical schools have not used "the scientific method to [deal with] the psychological and social as well as the somatic dimensions of illness and patient care" (10).

Here we have Dr. Engel's diagnosis of the disease that has afflicted medical education. It is this highly contagious disorder of the central nervous system for which there is no known physiochemical cure--biomedical dogmatitis--that is largely responsible for much of the current medical malpractice crisis. And what is Dr. Engel's recommended cure? It is to broaden the medical school curriculum by adding to the courses that now dominate the curriculum and that concentrate upon the physiochemistry of tissue systems, new courses on the "scientific approach to the psychosocial" (16). By doing so, malpractice exposure will be minimized because "in respect to malpractice we surely can agree that complaints are brought not by satisfied patients but by those who are angry, frustrated, or disappointed" (16).

With the exception of one further important element, which I will consider separately below, I believe I have fairly stated Dr. Engel's diagnosis and proposed cure for at least diminishing the severity of the current medical malpractice crisis.

* Page references to Dr. Engel's paper in this volume are indicated by the number in parenthesis.
Before turning to some of the more theoretical features of Dr. Engel's diagnosis and cure, let me call your attention to what I regard as the emotionally objectionable quality to the way Dr. Engel perceives of the cure for the malpractice crisis. He does not advise us to solve the problem by finding better cures for the disorders that patients suffer, but rather we should solve the problem by "scientifically" dealing with the "psychosocial dimension of medicine" so that we will not confront "complaints brought by [dis]satisfied patients [who] ... are angry, frustrated, or disappointed ...." Is Dr. Engel telling us, what is no doubt true, that patients who "love" their doctors are less likely to sue than patients who are angry with their doctors, and therefore doctors would be well advised to be sure they leave their patients happy? What is more, to leave your patients happy, apply the scientific principles of interpersonal manipulations and don't trust to the old-fashioned country doctor approach. And Dr. Engel is very scientific in making it clear that he does not mean by "scientific approaches to the psychosocial dimensions of medicine" anything like the country doctor approach to medicine. It is not just a human and humane concern with patients and knowledge about their personal status and situation, such as the mythical country doctor supposedly had, which Dr. Engel intends by "scientific approaches." No, he spends many pages making it clear that the mythical country doctor is not what he wants to inject into modern medicine.

Unfortunately, although Dr. Engel does tell us that country doctoring is not a "scientific approach," he does not tell us anything about what it is. This is why his cure for malpractice--leave patients satisfied--is emotionally grating. His scientific approach sounds too much like the principles of scientific salesmanship, which also have as their objective--leave the customers satisfied.

I suggested above that although I had fairly described Dr. Engel's diagnosis and cure, there was one further feature that would be considered separately. It is his important idea, unfortunately not developed in this paper, that if doctors do apply a "scientific approach to the psychosocial dimensions of medicine" they will avoid malpractice not just because they leave their customers smiling. Rather, patients will leave smiling and satisfied because such doctors are less "prone to make diagnostic errors and to resort to procedures and treatments that in themselves increase the risk of injury" (16). The important point here is that one of the most important functions of the doctor is not only to listen to the patient's verbal reports about his suffering, but to "hear" with his trained inner ear what the patient is "telling" the doctor about his "physical, psychological and social processes" (12). Dr. Engel's crucial suggestion is that doctors who use the "scientific approach" will "hear" more and better than even the country doctor and therefore will be less likely to make shotgun diagnoses that then, in turn, require shotgun diagnostic tests or treatments. Thus, such doctors will not only leave their customers satisfied, but will leave them satisfied for the right reasons.
This is indeed a powerful theory—it is therefore all the more regrettable that Dr. Engel has not elucidated what it means to "hear" scientifically. The cases he offers to illustrate the difference between listening and hearing do indeed show that there is a difference, but not what characterizes that difference. In other words, he fails to offer any systematic, intersubjectively testable criteria for identifying his "scientific approach." His several anecdotal cases, though interesting, came nowhere near what is required.

If the following two propositions could be established, then even if doctors do use the "scientific approach" to manipulate their patients, not in order to leave them smiling, but to discover what is wrong with them, Dr. Engel's cure for the malpractice crisis would be much less objectionable even on moral grounds. The two propositions he needs to establish, but has not, are these:

1. Doctors who use a "scientific approach to the psychosocial dimensions of medicine" are more likely to make a proper diagnosis and hence more likely, properly, to treat the treatable or identify the untreatable.

2. There are "scientific principles" that can be communicated to medical students about how to listen, look, and perceive which will enable them, or at least significantly better enable them, to hear, see, and appreciate what their patients tell them and try to tell them.

IV

Let me turn now to what are referred to above as some of the more theoretical questions raised by Dr. Engel's diagnosis and cure. To better enable you to appreciate why I view some of these theoretical matters the way I do, it may be helpful if I disclose that for the past two years I have been working on a book (to be published this year by my university press) entitled: Psychosurgery and the Medical Control of Violence. Thus, it has been in the context of a very special kind of medical procedure that I have been examining what Dr. Engel refers to as the biomedical model and biomedical reductionism or dogma. Perhaps colored by the special context within which I have been examining the matter, it seems to me that a much more specific analysis is warranted before attributing the medical malpractice crisis to the dominance of the biomedical model. With this special background in mind, I want to ask whether the crisis is rather due to the insufficiently dogmatic application of the model.

As I shall try to show, the crisis is due not so much to either the dogmatic application of the biomedical model or to the insufficiently dogmatic application of the model, but is rather due to the misapplication of that model. With the steady erosion of the domain within which political authority is viewed as legitimate, and with the equally pervasive decay of familial authority accompanied by the demise of religious authority, nature once again has proven how much she abhors a vacuum. It should come as hardly a surprise that virtually the only successful human disorder
specialists (physicians), backed by the medical model, stepped into the vacuum and did so with the universal blessing of government, family, and even church. By condoning the application of the "medical model" to the problems that they could no longer handle, government, family, and church enhanced their own tarnished legitimacy. By acceding to the territorial imperialism of medicine, government, family, and church have legitimated the use of the biomedical model as the approved way of dealing with, among other problems, political dissenters, "underachieving" and disobedient children, marital problems, and clergy so abnormal that they wanted to democratize the church and even marry. Furthermore, the territorial expansionism that is probably natural for any profession has, in the case of physicians, been further abetted by the imperialistic World Health Organization's definition of "health" as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." There has thus been a reciprocally advantageous relation between medicine on the one hand and on the other, church, state and family. The latter, by approving and encouraging expansion of the constituency for the medical specialists, co-opted the potential threat to their legitimacy--a modern, large-scale example of the old adage, "If you can't beat 'em, join 'em!" By joining together in this political adventure, medicine, church, family, and state each seems to get everything it wants, and it seems almost ungracious to ask: What has happened to the patient?

Now, what has this to do with malpractice? Dr. Engel suggested that the dogmatic application of the biomedical model has discouraged application of the scientific approach to the psychosocial dimension of medicine, resulting in dissatisfied patients who then sue their doctors. On the contrary, I am here asking if many of the disorders with which doctors now deal are properly to be dealt with by doctors at all. It is not merely that medical doctors often fail to deal properly with the psychosocial dimensions of their patients' disorders; it is, rather, that there may well be nothing about many such disorders that should even make us think that medical doctors are the appropriate source for "treatment." Indeed, I wonder whether it does not make more sense to say that if at least a significant feature of the patient's disorder is not physiochemical or anatomical, then what is it about medical doctors that makes them the right people from whom to expect help?

It is very important that I not be misunderstood here to imply that it is inappropriate for physicians to use scientific principles in manipulating patients so that they can properly develop case histories. Nor am I suggesting that because we do not yet know just what is covered by Dr. Engel's scientific approach to patients and their care, therefore we should reject the possibility of such an approach. Rather, I am suggesting a different, but radical, thesis. It is that much of the malpractice crisis is due to the unreasonable expectations that physicians (with the cooperation of church, state, and family) have encouraged. And they have been able to create these unreasonable expectations precisely because of the dramatic successes of the biomedical model.
These expectations have arisen because when modern physicians do what they are trained to do, i.e., apply the biomedical model to disorders to which that model is applicable, they are dramatically successful. Consequently, when one consults a physician, it is not unreasonable to expect that he will do precisely what he has been trained to do and expected to do—that is, search for the anatomical or physiochemical causes of the malfunctioning tissue systems and proceed to use surgery, chemotherapy, or other essentially physicalistic means of treatment. Or, in the alternative, at least tell the patient, I have found no disorder for which I, as a medical doctor, am uniquely qualified to furnish assistance; your disorder is not one to which the biomedical model applies. Were physicians to do this, I believe some of the more serious aspects of the modern malpractice crisis would become manageable. Malpractice problems will not disappear, but at least we would then have the minimum intellectual and theoretical clarity about the doctoring role that would enable us to develop realistic criteria of accountability against which to determine negligence.

The physician's willingness to accept employment for the treatment of disorders that have no physiochemical base is all the more objectionable precisely because of the fact that in doing so the physician may be exploiting the doctor-patient relationship. An intrinsic and crucial element of the relationship between doctor and patient is that the patient must have considerable faith in his doctor. No matter how fully the doctor discloses to the patient what are the options for, and consequences of, dealing with the patient's disorder, the patient will almost always, in the end, be compelled to rest heavily upon faith in his doctor. He must place this heavy reliance upon faith largely because the patient cannot possibly acquire the necessary data-base about the physiochemistry of his disorder that will enable him to compete with the physician in deciding what is the biomedically preferable alternative. But is the data-base upon which physicians base their judgments equally technical and therefore beyond the ready grasp of the patient when the disorder is not physiochemical in origin? Is there some data-base about allegedly errant clergy, sex, or "unmanageable" children that is both generally shared by the relevant professions and so technical that the patient must accept on faith whatever the health care professional recommends? Because much of what physicians do when they "treat" complaints that are not physiochemical is seat-of-the-pants country doctoring, I raise the question of whether there is not an abuse of the faith which the patient has shown by bringing his complaint to the doctor in the first place. Nor can the doctor defend his exploitation of the patient's faith in these cases by arguing that he acts only for the best interests of the patient. Such medical paternalism will, in the end, not only invite, but necessitate, not less, but more, malpractice. Dr. Engel is surely correct in urging that a revival of old-fashioned country doctoring is not what will help cure the malpractice crisis. Even if country doctoring leaves the customers satisfied, at best it does so for the wrong reasons, and therefore cannot make any durable contribution to the kind of modern, scientific practice of medicine that will make it possible to distinguish bad medical practice (malpractice, properly so called) from the (wrong) use of a medical license to charge for
pretending to treat, as a physician, that which is not within the special competence of one trained as a physician.

I realize that all of the above discussion is subject to special considerations in connection with psychiatrists who, at least in America, are also physicians. But, in the context of our present concern--medical malpractice--I shall here ignore these special problems. It is worth noting, however, that the malpractice premium of psychiatrists reflects the very low level of alleged psychiatric malpractice. One reason for this may be that consumers do not expect biomedical miracles when they consult a psychiatrist about a disorder that the consumer does not perceive as one which is likely to be amenable to the biomedical model.

If we continue wrongly to expect physicians to furnish allegedly biomedical solutions to the problems of violence, unruly children, and "errant" clergymen when there is no biological basis for the imposed solution, and if physicians continue to operate under the guise of the biomedical model when dealing with disorders to which that model has no applicability, then we cannot expect to untangle the theoretical or practical problems that make up the current malpractice crises. Instead, realistically, we must expect them to get worse. While I am not overly optimistic about any near future solution to the underlying problems, there are a couple of encouraging developments.

First, the new vigor with which other health professionals are now asserting their claims to direct payment from insurance carriers may encourage some meaningful dialogue as to the kinds of "treatment" that a patient should have. If physicians can no longer monopolize all treatment options (under the pretense that the biomedical model warrants such monopolization), it may become possible to do two things: First, to educate health consumers to abandon their mistaken belief that there is a biomedical explanation or cure available for every perceived disorder. Second, to educate physicians to encourage patients to utilize health professionals, other than physicians, who may be able to apply to their psychosocial problems what Dr. Engel has called the "scientific approach." If these two goals of education could be achieved, then health care professionals who are not physicians would be less wary about losing customers if, when initially consulted by a consumer, they suspect that there may be some feature of the disorder to which the biomedical model is applicable. Under the circumstances which presently obtain where patients believe, and are encouraged by their physicians to believe, that only their medical doctors can deal with disorders, other health care professionals rightly fear the loss of even their appropriate customers and are, therefore, deeply reluctant to require consultation with a physician even when it should be encouraged. If the consumer could have a freedom of choice from among these state-licensed health professionals who allege to be able to offer some help and, if the physicians, be they psychiatrists or not, would tell their consumers that the disorder of which the consumer complains is not presently amenable to the biomedical model, then we will have done much to discourage health consumers from suffering unrealistic expectations about
their physicians (or other health professionals). For health consumers, thus freed from inappropriate expectations, we may then hope that not only "can we leave 'em smiling," but even more important—we can leave them smiling for the right reason.

By way of conclusion, permit me to add two points. First, I argued above that Dr. Engel did not show what was meant by the "scientific approach" to the psychosocial aspects of a disorder, and that this omission is critical to his thesis. What is here troublesome is not just that Dr. Engel did not show what was meant by such an approach, but rather whether he, or anyone else, can make the necessary showing. Indeed, what bothers me here is the realization that there is probably no one in American psychiatry or perhaps in American medicine who may be better qualified than Dr. Engel to make this showing.

Those of you who are not psychiatrists may not realize that Dr. Engel has an international reputation for his work on psychosomatic disorders, and as one of the leading clinicians in the country. Furthermore, together with Dr. Romano, he has done work on the clinical, biological, and psychiatric aspects of delirium, that is acknowledged as a paradigm of scientific research. As a result of that research, delirium was rescued from psychological mumbo jumbo and has become an understandable and psychiatrically manageable disorder. Now, if with that background Dr. Engel does not elaborate the concept of "scientific approach," and despite his protests to the contrary, are we not warranted in asking: Is the "scientific approach" art rather than science?

The second point is this: Much of what I have argued above about the need to satisfy patients (by informing them of the fact that although they have come to see a biomedical specialist, he may not be able to apply the biomedical model to their complaint) is very closely related to the main thrust of Dr. Lewis' precirculated paper. He forcefully argues that medical authoritarianism, or what I prefer to call medical colonialism, must be replaced by a new kind of doctor-patient relationship that accords proper respect to the patient's right to decide what shall happen to him and this includes deciding about a medical intervention. Applied to my suggestion, this means informing the patient as to those of his complaints which are not amenable to the biomedical model. Having thus lifted the veil of ignorance that permitted the patient to have unrealistic expectations about being cured by a biomedical intervention, the patient may then exercise his freedom of choice in deciding whether he wishes to be treated by someone (the physician) who happens also to be a biomedical specialist, or by someone else, who is not (also) that kind of specialist. Enlightened, and therefore more freely choosing, the patient is less likely to be dissatisfied and therefore less likely to seek redress through litigation.

My point here is that even if what a physician, or some other health care professional, does do in dealing with the psychosocial aspects of a patient's disorder is art, and not science, there will be less dissatisfaction if the patient, having once entered the medical care supermarket,
freely and knowingly chooses from the shelves. Much of the present malpractice crisis has been precipitated by the exploitation of the success of the biomedical model. By inducing, or at least encouraging, patients to believe that whenever they are charged for services rendered by a physician, they are being charged for biomedical services, patients are misled and even intimidated into foregoing their right, and it is a right, to choose freely from the shelves of the health care supermarket. If it turns out that Dr. Engel is right, and there is some teachable scientific approach to the psychosocial aspects of a patient's disorder, it will still require demonstrating that the approach is one properly vested only in the hands of those who are also specialists in the biomedical model, i.e., physicians. Otherwise, it will still be improper to remove from the health care shelves those who are not physicians but who are properly educated in the practice of the scientific approach—psychologists, social workers, etc. But if it cannot be shown that the "scientific approach" is necessarily connected with specialization in the biomedical model, then it will be necessary to remove from the shelves those not trained or qualified in respect to that requisite specialty—be they physicians or not.

Legitimate medical or state paternalism permits that shelf space be denied only when reasonably prudent health care consumers cannot protect themselves from fraud. It is therefore appropriate to restrict heart or brain surgery to those with the necessary qualifications, and one hopes that eventually there may even be appropriate qualifications imposed upon health care professionals who purport to furnish mental health services. When such qualifications are imposed, then heart surgeons as well as podiatrists will be unable to charge for psychiatric services, and perhaps some psychologists or social workers will be able to charge. But the important point for us is that the legitimate right of the health care consumer to choose from the shelves not be compromised by the usually self-serving medical "paternalism," which ends up leaving consumers dissatisfied, and quite properly so, when they are prevented from choosing nonbiomedical services on the ground that only biomedical services can furnish the cure—and then the consumer learns that his disorder is not even within the purview of the biomedical model. Is it any wonder if such a patient ends up saying: "I'll sue the hell out of the S-O-B!"
The informal discussion between Engel and Shuman immediately following their formal presentations brought out that both speakers agreed that problems arise which contribute both to medical malpractice and malpractice litigation when the biomedical model is misapplied. They agreed that the dogmatic applications of the biomedical model to non-medical problems, such as management of antisocial behavior, is inappropriate. But they disagreed about the extent to which scientific medicine can be practiced and taught.

Engel believes that the biomedical model alone is inadequate for the diagnosis and treatment of disease and illness. The biomedical dimension must be supplemented by scientific analysis of the psychosocial dimensions of disease and illness. Engel argued that physicians and other members of the health professional team must be taught to include psychosocial factors in making diagnoses and prescribing treatments. For example, recognizing gestures of helplessness or expressions of distress may provide important clues about appropriate treatment for a particular patient. Physicians must become sensitive to psychological manifestations of illness and respond therapeutically to them. As a result they will be both more competent as physicians in caring for their patient and more likely to elicit patient satisfaction than are physicians who respond only to physiological dimensions of illness or disease. Engel also observed that the issue of patient satisfaction is one that transcends the issue of malpractice litigation. The patient's frame of mind is a significant variable in altering both susceptibility to disease and prospects for cure. Physicians should be attuned to the importance of this factor at all times during their interrelationships with patients.

The disagreement between Engel and Shuman was whether the principles advocated by Engel as necessary for inclusion in medical education are susceptible to scientific analysis and teaching. Thus, Professor Shuman, while agreeing that it is important to distinguish between the biomedical and the psychosocial dimensions of illness and disease, questioned the scientific status of the principles advocated by Engel. Shuman does not believe that the psychosocial dimension of disease is amenable to scientific study and treatment. Rather, he believes that physicians should restrict their activities to those which clearly fall within the confines of the biomedical model.

Shuman expressed doubts whether scientific principles for teaching about the psychosocial dimensions of illness and disease exist. He suggested that students can learn to appreciate the psychosocial aspects of medical practice only through modeling their behavior on that of experienced and sensitive clinicians. Physicians should be trained to distinguish between their professional-biomedical competence and humane and sensitive but nonscientific responses to patients.
Next the following question was raised by Dr. Milton Roemer:

"I wonder if the question is not whether psychosocial aspects of illness and ways to cope with it are teachable, but, rather, whether both the biomedical aspects, which are so enormously complex, and the psychosocial aspects can be taught effectively to the same person. There may be some who can master both, but isn't there an implicit suggestion that in order to cope effectively with illnesses which involve both the somatic and the psychosocial, we really need teams of personnel whose members are variously skilled in different aspects that relate to both diagnosis and treatment?"

Dr. Engel agreed that a team approach to the psychosocial aspects of medical care is sometimes desirable, but he emphasized that physicians must play a leading role in integrating the biomedical and psychosocial approaches. He added that it has been his experience, after thirty years of teaching in a post-residency graduate program with internists, gynecologists, pediatricians, neurologists, and others, that the effectiveness of such educational efforts can be readily observed even though it is extraordinarily difficult to measure it in quantitative terms.

Others in the audience echoed Dr. Roemer's suggestion that a division of labor among the medical care team might be necessary to provide adequate attention to the psychosocial aspect of illness. The issue of division of labor was raised concerning what it is educationally desirable and feasible to teach, what it is practically possible to expect a physician to do, and what it is reasonable to ask a patient to pay.

Dr. Engel reiterated that physicians as well as other health care professionals should acquire skills in the psychological and behavioral sciences and apply them in their practice. Furthermore, he argued that properly trained professionals will be more accurate in diagnosis, more effective in determining treatment, and more efficient in the use of their time. However, some of those who agreed with Dr. Engel about the importance of teaching, learning, and utilizing psychosocial skills in medical care differed in that they believe that both division of labor and specialized competencies are therapeutically sound and economically prudent practices.

The comments of Dr. Charles Hughes were helpful in restructuring the focal issue of the discussion. He agreed that the specialists among the health care professionals should be the ones to address certain problems when those problems have been identified. However, the patient will not always be aware of the psychosocial aspects of his illness. The patient may not realize that, in some situations, it is not the services of the biomedical physician but rather, for example, those of the psychiatric social worker that are needed. The physician is in the position
of confronting the "whole patient" and must be adept at recognizing and treating the psychosocial component of the illness in the process of directing the patient to the appropriate specialist.

Hughes also made an interesting observation concerning the inability of physicians to recognize the psychosocial symptoms Engel illustrated. This failure may be due to certain characteristics of the physician which may cause him/her to feel uncomfortable in dealing with psychosocial features of an illness, especially if the physician feels unable to provide treatment for such problems. Doctors should be encouraged to learn how to identify and utilize relevant psychosocial data in providing medical treatment. In addition, by means of personal therapy, counseling or other training, which will help a physician to be more sensitive to his/her own needs and anxieties, a physician will be able to deal more satisfactorily with a patient's needs and anxieties.

It is the opinion of the editors that the issues that were raised in this discussion are especially relevant to the topic of medical malpractice and malpractice litigation. Although data are scanty and more research is needed, it does seem plausible that some mistakes of omission and commission in medical care might be prevented by the training of health professionals who are sensitive to biopsychosocial aspects of illness and disease. Patient satisfaction with medical care will likely be increased not only because the patient's disease will be treated biomedically, as anticipated, but also because the patient will be treated as a whole person. The goal is to increase patient satisfaction with medical care by providing it in a more careful and caring manner.
SECTION II

PATIENTS' RIGHTS

AND

PHYSICIANS' RESPONSIBILITIES:

A GROWING SOURCE OF SOCIAL CONFLICT
PATIENTS' RIGHTS AND PHYSICIANS' RESPONSIBILITIES:

A GROWING SOURCE OF SOCIAL CONFLICT

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The health care and legal systems, both essential to the functioning of society, have goals that are similar in many ways. The objectives of health services are to protect individuals from the consequences of illness and injury, to relieve distress, and to maintain and promote the health of the public. The legal system is designed to maintain the laws of the land and promote justice, to protect members of society from the actions of those who do not abide by these laws, and to provide a means for individuals suffering injury and distress at the hands of others to obtain fiscal relief.

Both systems are operated/dominated by highly educated professionals. Although they differ considerably in certain value orientations, their objectives are quite similar, i.e., to serve the people and to meet their own needs, be they intellectual, social, or economic. While lawyers and physicians spend long periods being schooled, the behavior of the members of both groups of practitioners are shaped significantly by the reinforcements of the real world. There are data to suggest that their performances as practitioners of medicine or law are not highly associated with their functions as students of these professions.\textsuperscript{2,3}

Despite rigorous efforts of selection committees, faculties, and licensing authorities, a small proportion of each group demonstrates behaviors that embarrass their colleagues. There is no evidence, to my knowledge, that the prevalence of "quacks" is significantly different from the prevalence of "shysters."

The health care system focuses on problems related to imbalances among host, agent, and environmental factors that produce states of disease. The functions of this system are dependent upon the state of knowledge in the sciences basic to the practice of the profession, the available technology that may be applied in the diagnosis and treatment of the problems, as well as the socialization or educational experiences that shape the orientations and technical competence of practitioners. The methods of financing and organizing health services also are significant determinants of the workings of the system. The latter are related more to the values that prevail in society (especially among practitioners) than the state of the art/science of medicine.

The legal system also operates on problems resulting from interactions among elements of society. Its functions are dependent upon accumulated historical statements of society's values and ideals, i.e., laws, instead of accumulated scientific knowledge. The practices of lawyers are governed by educational experiences, the results of contemporary court decisions (an evolutionary process productive of legal transformations), and the reinforcements provided in their world of practice.

These two systems are not completely independent. Their area of overlap or joint responsibility is concerned with many highly charged
issues. Together their practitioners must render judgments as to who is responsible/nonresponsible, or who is sane/insane. These two systems also are jointly involved in the specification of rules and regulations related to the practice of a health-related profession, and the means of protecting society from incompetent practitioners. Lawyers and physicians interact (often violently) in the process of prescribing sanctions against those practitioners judged to be incompetent. Considering the nature of the problems dealt with jointly by the two systems, in terms of the social, political, ethical, and/or medical implications of their resolution, it is not surprising that there is considerable conflict among those involved. However, difficulties surrounding their joint activities concerned with the malpractice of medicine have reached enormous proportions. Responses to these difficulties have resulted in a "crisis" with some physicians withdrawing from practice rather than pay the required insurance premiums.

A variety of factors have been blamed for this crisis. I suggest that the dilemma represents one of the manifestations of the failure of two (or more) of society's support systems to evolve in a coordinated fashion during a time of rapid social change. The forces that affect society as a whole, be they technological, economic, or political are transmitted to and influence the functioning of its component parts. Those activities which require intersystem collaboration may be affected by differential responses to change within the systems involved.

Efforts that are dependent upon the inputs from the members of more than one system or profession are difficult under any conditions. Those involved (such as in law and medicine) may have different orientations or value systems. Often they do not share a common knowledge base for decision-making. Under such circumstances, collaboration depends on negotiation and careful consideration of the ultimate consequences of their actions. Initially, their views of a problem are likely to reflect the rights of their profession, as seen by them, rather than their responsibilities to society. During periods of rapid social change, there is less opportunity for re-equilibration to occur, through deliberation, testing, and negotiation. As a result, the systems involved may respond with unilaterally derived short-term solutions that have disastrous long-term consequences for society.

In subsequent sections of this paper, I shall briefly review the data that indicate there is a problem/crisis, discuss the alleged causes, and suggest a conceptual framework for an analysis of the problem as well as solutions. In so doing, I shall emphasize the extent to which medical education has contributed to the problem and could help in its solution.

Past History

Over the past decade, there has been rapid growth in the frequency of malpractice claims, litigation, and awards. It has been estimated
that from 1966 to 1970 an increase of 80 percent in the absolute fre-
quency of claims occurred, with a minimal change in the level of awards. During the same interval, costs increased over 350 percent. Since 1970, there has been a consistent increase in costs of insurance coverage, the amounts of awards, and the frequency of claims. However, there have been considerable variations in the sizes of awards and frequencies of claims among states at any point in time, and over time. The costs of malpractice insurance premiums for physicians in different states have increased at variable rates also.

The absence of valid and reliable data on malpractice claims and awards suggests something about the relatively rapid evolution of the problem, as well as the lack of foresight that characterizes most research on the workings of health services. A national sample of malpractice claims was reviewed by the Commission on Medical Malpractice of the Department of Health, Education, and Welfare in 1972. This may be the only study of a reasonable sample of the claims against individual practitioners (but not hospitals).

The analyses of these data produced a variety of "facts." For example, the poor and the elderly tended to receive lower payments and settled earlier in the process of litigation. Women received payment more frequently than men, and there was no significant difference in the average payment to the two sexes. There are many inconsistencies reported that may be related to differences in laws and legal-medical system behavior among states. Studies related to the variation among types of physicians resulted in statements such as the extent to which orthopedic surgeons are overrepresented in terms of physicians insured, and the number of claims paid. A brief review of the available data suggests that no analyses have attempted to examine the importance of different variables, as well as their interactions, as they relate to both the filing and payment of claims.

The Etiology of the Problem

The causes that have been described as productive of the malpractice crisis include: (1) Drift in legal rulings away from the requirement of proof of negligence toward a tendency to rule the physician liable for any adverse outcome; (2) deterioration of relationships between physicians and patients; (3) changes in the technical nature of medical practice; (4) a reduction in the overall competence of physicians; and (5) the availability of contingency fees for lawyers. These are only a few of the more frequently cited causes. Some of these will be examined in more detail.

Tort and Retort

Tort actions are as fundamental to the way of life of the legal profession as the performance of a physical examination is for physicians.*

* To eliminate this content from the curriculum of a law school might be analogous to dropping all courses related to pharmacology from medical schools.
When applied to "wrongs" arising from the acts of physicians, the purpose of such actions is to compensate individuals injured through negligence (or by intent) and to motivate competence on the part of the profession. For the procedure to operate effectively and as intended, an injury must occur as a consequence of physician incompetence/negligence, the injury must be identifiable and quantitatively measured, and subsequently translated into a monetary award. However, an analysis of the results of the operation of this mechanism suggests that many injuries are not identified and/or not quantified, and that the legal practitioner's ability to affect the emotions of jurors may be quite important in determining the magnitude of the award in many cases. This is especially true when the injury is difficult to measure quantitatively (medicine's problem) and to equate with economic loss (society's problem).

Over the past years, there has been an increase in the willingness of the courts to be satisfied that the demonstration of injury is a manifestation of negligence under the legal doctrine of res ipsa loquitur.

The Medical Arms Race

Changes in the nature of medical practice, per se, have contributed to the problem. A rapidly expanding armamentarium of drugs and procedures has increased the probability that physicians will inflict injury on patients as a consequence of providing the "best" care available. Prior to the development of procedures such as dye-contrast radiography, percutaneous biopsies, and cyto-toxic drugs, patients received less "cure," but they also required less "after cure" care. Thanks to our investment in basic research and the development of its applications, physicians are able to do much more with regard to the diagnosis and treatment of disease, utilizing procedures that, by their very nature, carry increased risks for the patient.

Most procedures that involve risks to a patient are employed by ethical, well-meaning physicians who do not advocate their use if there is a safer and equally effective procedure/drug (and if they are aware of the risk-benefit ratios of various alternatives). Most of the technical interventions that carry with them a real risk of morbidity and mortality are indicated at least from the medical point of view. Whether or not they are indicated from the patient's perspective is not known, despite the emphasis on "informed consent." It is current practice to require patients to sign statements indicating that they have been apprised of the possible adverse consequences of treatments/procedures. There is no research, that I am aware of, related to the validity and reliability of this process. I sincerely doubt whether patients, during a very stressful time in their lives, can rapidly process cognitive information describing the statistical probabilities of losing their lives, limbs, hair, or breasts, and arrive at truly "informed" decisions.
There has been an increasing tendency to compensate not only those injuries inflicted as a result of acts of commission and omission by incompetent practitioners, but also injuries occurring with a statistically predictable frequency, when treatments are carried out under the best possible circumstances by the most qualified practitioners. Malpractice awards made to "informed" patients who are injured in the process of providing the "best medical care available" seem to violate the basic premises of the tort system as a means of disciplining the profession, as well as recompensing the patient. The inclusion of adverse reactions to "reasonable care" under the rubric of malpractice may be an admirable way of reducing the frequency of performance of certain high risk procedures/treatments, or socially ensuring the statistically unfortunate. However, when carried out by a mechanism designed to accomplish another goal, in an environment where reinforcements are provided for the filing of claims essentially without risk to attorneys, it would seem to be socially irresponsible.

What Price Happiness?

Data suggest that malpractice claims are not randomly distributed among the population of both providers or consumers. Not all cases of negligence result in malpractice claims, and some claims made against physicians seem to be primarily a result of mal-relations. There are at least two sources--societal and professional--of patient dissatisfaction. The overall capabilities of medicine have been grossly exaggerated during an era when society has become increasingly concerned with quantification and the attribution of causality. People expect results and when success does not occur, they want to know why, and who was at fault. The rapid escalation of expectations for optimal results of a process that is still, by and large, inexact, sets the stage for patient dissatisfaction with other than perfect outcomes.

The same folks who gave you the rapid advances in scientific medicine and technology are also responsible for the education of physicians. Analyses of curricula document the enormous demands placed upon medical students to acquire the basic scientific information necessary to become a physician. Some feel that concomitantly there has been a displacement of concern for the "individual." The science of diagnosis and cure seems to have expanded to displace the art of care. The fault cannot be attributed solely to medical education. There has been a demand for "the best" in medical practice from the lay public. Physicians, however, have been more than willing to encourage the further dependency of individuals upon the health care system, and to respond predictably to the adulation and fees paid to "miracle workers."

An interesting paradox emerges: a scientifically oriented society has greater expectations, more need to attribute causality, and is intolerant of poor results. At the same time, patients want the comfort
and support that doctors are expected to provide. The response by the medical profession to expressions of dissatisfaction by patients has been to increase their defensive practices, including referrals. This increases the costs of services and further exaggerates the orientation towards technology as the answer to all problems. Too often our response to criticism has been the assumption of a posture of authoritarian arrogance and to question the patient's right to challenge us.

The Rights (and Responsibilities) of Providers and Consumers

American society is based upon certain beliefs about the rights of individuals. There is also a basic assumption that some responsibilities are associated with these rights. There has been a great deal of discussion about the rights of individuals in the health care system. There have been few, if any, comments about the responsibilities of those involved.

I previously suggested that the malpractice crisis was a symptom of the failure of the legal and health care systems to respond to forces producing social change in a manner that permitted the optimal management of problems of joint concern. The health care system itself, however, has failed to respond adequately to social change. There are increasing differences in the way patients and physicians view their respective roles in the existing system.

It might be interesting to imagine an arrangement wherein everyone had only rights and no responsibilities. In fact, such a state of anarchy might not be too dissimilar from the status that prevails in our current health care system. However, in most viable social arrangements, rights and responsibilities bear some reciprocal relationships. Figure A. (see next page) illustrates the associations between the comparative rights and responsibilities of those involved in transactions related to health care. It is intended to be both descriptive and prescriptive.

Rights

There are certain rights common to both providers and consumers. These include maintenance of the confidentiality of information provided and received in the process of receiving and giving care. Both parties are depicted as having a right to freedom of choice, i.e., the patient to select a doctor of his/her choice, and a physician to accept or refuse to see a patient when that patient has a viable option to find another physician. (This would not apply in emergencies and one-physician communities.)
FIGURE A

PATIENTS'

RIGHTS

Confidentiality
Free Choice

RESPONSIBILITIES

Payment

PHYSICIANS'

RIGHTS

High Quality Care
Information (consent re risks)
Access to Care
Involvement in Decisions

RESPONSIBILITIES

Compliance
Satisfaction
Contractual Agreements
Responsibilities and Rights

The physician has the right to receive payment, and the patient the responsibility to pay either directly or indirectly for services received. Patients also have a right to receive care of high quality, to have access to care, and to have full disclosure of the risks related to diagnostic and treatment programs proposed, i.e., to consent as informed consumers of services. All these rights of patients are the responsibilities of physicians, i.e., to provide competent care in a manner that is fully comprehensible by the patient.

To this point, I have described the way individuals view their roles. The underlined terms in the chart represent my prescription for the future. I suggest that patient and physician have a joint responsibility to each other, to respect each other's roles in the process of giving and receiving care. The physician has the responsibility to outline clearly what he expects of the patient and what he/she is capable of doing for the patient, versus that which the patient must do for himself. Conversely, the patient has the responsibility of appropriately utilizing resources by complying to the best of his or her ability with these recommendations. Satisfaction is included to indicate that under ideal circumstances each of the parties should satisfy the other. If the transaction occurs in the form of a social agreement or contract, as suggested, the probability of mutual satisfaction as a result of achieving mutually agreed upon goals is enhanced. Above all, the patient has the right to participate, not just in high-risk decisions, but in all decisions related to his/her care.

The involvement of the patient as decision maker is not only a social issue (a "right"). It is also the means of improving their health and illness behaviors, including compliance with recommendations for treatment.

Proposed Solutions

Any solution of this crisis must be based upon an accurate assessment of the pathophysiologic changes in the systems involved. The solutions that already have been proposed could be classified under several general headings.

1. Changing the law that assigns liability for injuries. These proposals include limiting the time after an "injury" that a physician may be held liable, i.e., altering the statute of limitations, instituting a no-fault system of compensation, or making physician liability contingent on proof of negligence.

2. Changes in judicial decision-making procedures. These proposals include a variety of methods for determining whether or not negligence was responsible for the injury, and if so, the amount of compensation to be awarded. The use of compulsory arbitration boards in place of
juries, regulation of awards, making payments over a long-term period rather than in a lump sum, and the regulation of attorney's fees are among the solutions offered.

3. Changes in insurance procedures. A variety of efforts have been promoted that would require joint underwriting associations, establish re-insurance pools, allow doctors to create their own insurance companies, etc. In some cases, state governments might provide subsidies to certain types of insurance pools.

4. Medical practice. A variety of suggestions have been made in an effort to increase the surveillance of physicians, and to identify those who are providing care of marginal or poor quality. These include limited licensure, required relicensure, with or without reexamination, increased monitoring through PSRO-type agencies, etc.

A recent report of the Advisory Commission on Medical Malpractice of the State Bar Association of California contained seventeen recommendations. Four of these might be subsumed under a category not previously mentioned, "God and motherhood." These included recommendations to study small claims, a stand against the ownership of hospitals by physicians, for catastrophic health insurance, etc. Many of the recommendations would maintain certain features of the tort system valued by lawyers. These include rejection of a no-fault insurance approach, a reaffirmation of the tort system, rejection of patients' compensation boards, support of contingency fees, and the doctrine of res ipsa loquitur.

At only one recommendation related to discipline of the health professions, it contained five subsections and covered one full page of the four-and-a-half page report.

The recommendations of this group, and other reports of its kind, should be predictable given the composition of the body. On a superficial level one might interpret such reports as reflecting the relative importance to one profession of the way the other makes a living.

At the present time there are four bills pending before the Congress that would deal with the malpractice problem.* All involve remedies such as no-fault insurance, compulsory review of physicians by PSRO's, national licensure and relicensure of physicians, joint underwriting, contingency fees, and reduced statutes of limitation. None is designed to deal with the factors related to styles of interaction based upon a definition of the mutual rights and responsibilities of physicians and patients.

* S-215 (Kennedy and Inouye), S-482, S-188 (Nelson), and HR:6100 (Hastings)
Since this conference is concerned with the relationship of medical education to malpractice litigation, my final remarks will be limited to the responsibilities of the medical profession, and more specifically, schools of medicine, to resolving what I perceive to be a multisystem problem. Any effective solution must deal with the problems lying within the intersect between the legal and health care system. It must also resolve those issues within the health care sector related to consumers' and providers' rights and responsibilities. Obviously an adequate "treatment" for the crisis must affect all the causes. Despite our general unwillingness to resort to polypharmacy, we must recognize that failure to deal with the basic factors will result in only temporary symptomatic relief.

I shall focus on the contribution of medical education toward this dilemma (as I perceive it), which has been considerable, as well as the possible solutions to our system's part of the problem. I am assuming that others will deal with the legal, adjudicational, and actuarial aspects of the problem.

Medical educators may not perceive it as their responsibility, let alone within their power, to deal with social values related to expectations from health care in a causality-oriented society. There are, however, three variables, or pieces of the puzzle, that are susceptible to influence by medical schools. They are: (1) the quality of technical performance of physicians; (2) the orientation of the physician to patient and/or disease; and (3) the fundamental nature of the doctor-patient interaction. I shall dwell no further on the first of these three, since I believe medical educators are adequately concerned (if not obsessed) with the pursuit of excellence in terms of scientific knowledge and the technical performance of medical students and physicians-in-training.

The consequences of technical incompetence are manifested primarily in three of the five "D's" used to assess the outcomes of care, i.e., deaths, diseases, and disability. The real challenge to medical education is to deal with greater competence with the other "D's"—discomfort and dissatisfaction. These are the "softest" outcomes of care, and ones dependent upon what most medical educators view as the "softer" (and therefore less important) sciences that may be only vaguely related to medical education.

Perhaps the time has come to examine the selection procedure for medical students in terms of the extent to which we choose future physicians concerned with meeting the needs of people, as well as their own intellectual and economic needs. It behooves us to ensure that in the process of education, our students are exposed not only to lectures in "ethics" or "how to make patients happy." They must be provided substantive content based on firm, conceptual grounds, translated into action by
role models who render these rather abstract concepts tangible. As of 1974, few medical schools and their hospitals were concerned with patient dissatisfaction and the ways that physicians and their institutions can deal with patient grievances and unhappiness.

We have long been concerned with the hard sell of hard science, as if it were totally sufficient in the preparation of a physician. If medicine and medical education had been more concerned with its public image, if we had been more concerned with pleasing those we serve, while rendering competent, scientifically based care (and the two are not mutually exclusive), we would have fewer problems in a variety of spheres.

Our failures to discuss and deal with these issues openly has its roots in what I believe is the most fundamental problem that must be dealt with in the health care system: the nature of transactions between patients and physicians. In the past we have operated on an authoritarian model, be it priest-healer, good father, or scientist-researcher. We have retained power by maintaining a sense of uncertainty. We have told patients what we feel they should know, written "orders," and been distressed at the extent that they either overuse, underuse, or are non-compliant with our recommendations for care. We are concerned that patients will have too many facts, and thus be unable to make up their minds or else make bad decisions. (They may be bad, but at least they will be their decisions.) There are many manifestations of the basic assumption that it is the doctor's right to prescribe and the patient's responsibility to do. In fact, medical care must be a transaction based upon mutual respect and the definition of complementary responsibilities if the results of care are to be achieved by doctor and patient.

Over a four-year period we encourage physicians-in-training to think in terms of quantitative information, using laboratory, history, and physical data. Many medical students (and physicians) assume that "patients" or lay people are incapable of performing the same cognitive operations as a "professional" in arriving at a decision. Certainly, when that decision involves risks to them, it is not only the physician's responsibility to see that this information is adequately conveyed to the patient, but the patient's right to determine what course of action will be taken.

I believe we are entering an era in which individual responsibility is taking on new dimensions. The patient who is not involved, both as an informed consumer and as a decision maker with regard to the processes that relate to his own care, is unlikely to be compliant. Noncompliant patients fail to achieve the optimal outcomes of care so dearly purchased through investments in education and the financing of services. There are fragmentary but adequate data in the literature to document the importance of the sharing of power in the transaction between patients and physician. Consumer participation in care need not be a rhetorical or

*The term, more familiar to most because of its use in defining changes in volume as a function of the application of pressure, is symbolic of the problem.
political issue; its value on a one-to-one basis can be documented by facts that are not taught or discussed in most schools of medicine.

Medical education can contribute to the solution of the malpractice problem, but it will not be easy. It involves a review of our criteria for selection of students, analyses of curricula, and more importantly, changes in criteria for the appointment and promotion of faculty members. Changes will not come easily, or rapidly, but they must come if many of our problems (and malpractice is just one of them) are to be resolved.

Some may view the issues discussed as not the responsibility of the medical schools, i.e., that such efforts should be mounted by medical associations or in house staff training programs. On the contrary, there is every reason to believe that since the subject matter described requires affective as well as cognitive learning, it must be integrated into the early socialization process of medical students, and reinforced in subsequent professional training experiences. If we believe that medical schools are social resources capable of objectively examining problems related to health care, and if we take seriously our responsibilities to society to produce practitioners prepared for "a lifetime of learning," we cannot fail to accept the challenge. We must study, demonstrate, and advocate those types of transactions between physicians and patients which improve the efficacy of our curative interventions for some, and our ability to comfort and care for all.
References


Editors' Addendum to Lewis paper

Instead of reading his prepared paper, Dr. Lewis briefly summarized its main themes and then proceeded to amplify his analysis by reference to his research on health care utilization by adults and children. The behavior of persons who seek or need health care is a very important clue to malpractice litigation. If, as the studies cited by Dr. Lewis indicate, many people seek medical care because of psychological and social complaints that cannot be cured by standard biomedical means, patient dissatisfaction is not likely to be removed through improved biomedical techniques.

Another relevant factor is that many persons who need medical care do not seek it soon enough; the likelihood of cure is decreased because the disease has progressed too far. Here, also, patient dissatisfaction is likely to result, especially if expectations about the possibility of cure are unrealistic. It would be interesting to study the antecedent expectations about medical care, and whether they are realistic or unrealistic, of those persons who become dissatisfied patients. Further, it would be valuable to determine what percentage of patients who engage in malpractice litigation are drawn from those whose dissatisfaction with medical care is derived in part from unrealistic expectations about medical care.

Dr. Lewis presented evidence that health care utilization is learned very early by children who presumably mirror parents' or other family members' beliefs, attitudes, behaviors. He then suggested that health care expectations are, at least to some extent, subject to both cognitive and affective educational methods. As a result of proper education about expectations, more appropriate utilization will be made of health care services. Dr. Lewis' contention is that effective health care requires patient responsibility in participating in the therapeutic decision-making process. Helping a patient to participate requires that health professionals be involved in health education. In order to train people effectively to become active in participating in their own health care, it is necessary to begin this training at a very early age.

The relevance of this to malpractice litigation is that most malpractice actions are not related to professional incompetence. Rather, according to Dr. Lewis, it is patient dissatisfaction that provides the impetus for much litigation. Patient satisfaction is likely to be increased if patients understand more fully the nature of, and play an active role in, their own health care. Shared responsibility can help to deflate unrealistic expectations and to defuse frustration about possibilities of cure, both of which are produced, in part, by ignorance.
Dr. Lewis went on to suggest how patients -- children as well as adults -- can play a more active role by taking greater responsibility for their own health through education in self-care techniques. First, patients can participate in decision-making concerning health care when they are given options, when appropriate, about therapeutic alternatives. Allowing patients to select options will reinforce their commitment to cooperate in and to comply with necessary therapeutic procedures. The fact that securing patient compliance is not an unimportant goal was dramatically pointed out by Dr. Lewis when he cited the figure of only 30 percent compliance by patients in following the recommendations of their doctors.

Whereas Dr. Engel stressed the importance of the need for biopsychosocial skills of physicians, Dr. Lewis emphasized that patients must also become more sensitive to those biopsychosocial aspects of their own minds and bodies. The combination of these perspectives provides the conceptual basis for an approach to the physician-patient relationship that places each term of the relationship on a more complex but more solid foundation.
COMMENTS ON PROFESSOR CHARLES E. LEWIS' PAPER:

Patients' Rights and Physicians' Responsibilities;

A Growing Social Conflict

Patricia Munch, Ph.D.

Dr. Munch, a research economist at the Rand Corporation, where her primary area of research is medical malpractice, has published articles on economic theory and medical malpractice.
The conceptual framework Professor Lewis suggests for analyzing the malpractice problem is one of rights and responsibilities. This framework is used in both describing the causes of the current crisis and prescribing a solution. This approach is useful because it focuses on the fundamental reason why malpractice is currently viewed as a problem, that is, the fact that frequency and size of malpractice claims have driven insurance premiums to a level physicians are unwilling to accept. A malpractice claim is a demand for income redistribution from the physician to the patient. Litigation over such a claim arises when the right to such a redistribution is in dispute. The courts rule on whether the physician in fact fulfilled his responsibilities and hence on the rights of the patient to compensation. Thus, rights and responsibilities, as Professor Lewis points out, are the essence of litigation, which is what has generated public awareness of the existence of a "malpractice crisis."

The more fundamental question of how to prevent the occurrence of malpractice, i.e., negligent practice by physicians, is not addressed by Professor Lewis. Yet this is crucial in evaluating the current "crisis" in claims. Malpractice claims perform two functions. First, there is the obvious function of compensating the injured patient. Second and more important, there is the function of deterrence or quality control. The basic purpose of negligence law in general and professional liability in particular is to deter negligent behavior by making a negligent party bear the costs of his actions. This is implicit in the legal definition of negligence, explicated by Judge Learned Hand's famous formulation of the negligence standard. In a negligence case, the judge (or jury) should attempt to measure three things: the magnitude of the loss if an accident occurs; the probability of the accident's occurring; and the cost of taking precautions that would avert it. If the product of the first two terms (i.e., the expected benefit from averting the accident) exceeds the cost of prevention, failure to take the necessary precautions is negligence. It can be shown that if the tort system functions perfectly in assessing tortfeasors for the amount of damages they inflict on their victims, it creates the appropriate incentives to bring about the efficient-cost justified-level of injury prevention. Among the conditions required for the tort system in practice to approach this theoretical ideal is that compensation should be effected (and hence the tortfeasor fined) in all cases of injury caused by negligence. If the probability is less than one that a negligent act will result in a successful suit, then the incentives to prevent injuries are inadequate. Thus, in examining the causes and consequences of an increase in the frequency of claims, the implications of claims for optimal injury prevention cannot be ignored.


2 United States vs. Carroll Towing Company, 159 F. 2d 169 (2d Cir. 1947); Conway vs. O'Brien, 111 F. 2d 611 (2d Cir. 1940). Cited in Posner, op. cit.
If we observe, as we do, an increase in the frequency of malpractice suits and assume no change in the underlying amount of negligent medical practice, we may conclude either that patients are asserting their rights vis-a-vis physicians more frequently than they did previously or that patient rights vis-a-vis physicians have been extended. The immediate question, which must be answered before evaluating proposed remedies, is which of these not mutually exclusive possibilities has occurred and why. Alternatively stated, the question is whether claims have increased because it has become easier or less costly to prove negligence or because the courts have shifted from a doctrine of liability for negligence to one of strict liability of the physician for any adverse outcome, regardless of whether negligence was involved. This question cannot be adequately answered here. However, many of the recent changes in legal rules relating to medical malpractice can be viewed as reducing the cost to the plaintiff of proving negligence, without moving beyond the negligence standard to one of strict liability. Changes of this type, which are frequently cited as having contributed to the increased frequency of claims, include the admission of medical texts as evidence, the abolition of the locality rule, and adoption of res ipsa loquitur.

Whether or not the surge in claims reflects a shift in legal doctrine from liability for negligence to strict liability has important implications for evaluating various proposed solutions, for the quality of medical care, and for the role of medical education. If the recent increase in claims activity is primarily the result of a reduction in the cost to the plaintiff of proving negligence, then there may have been a move in the right direction, from a frequency of compensation that previously conveyed an inadequate signal to the physician to prevent injuries. If the physician does not have to pay the true costs of his negligence, because many injuries resulting from negligence in fact go uncompensated, then his incentives to exercise care are insufficient. In other words, the costs he perceives of being negligent are less than the full social costs, because he discounts the expected cost of injury to the patient by the probability of a claim being successfully prosecuted. Since the probability of a claim being successfully prosecuted is inversely related to the costs to the patient of proving negligence, changes in legal doctrine or rules of evidence that reduce these costs and hence increase the number of suits brought have the beneficial effect of bringing us closer to the optimal amount of compensation and hence to the optimal amount of negligence avoidance.

In arguing that the expected award to an injured patient is the expected cost of negligence as perceived by the physician, I am ignoring the fact that liability insurance tends to impede this transmission of cost from patient to physician. The physician's insurance company, not the physician himself, typically pays a malpractice award, so the cost of the injury is only transmitted to the physician if his insurance premium is revised in the light of his personal record, which is uncommon in medical liability insurance. However, even in the absence of perfect experience rating, some of the cost of claims is transmitted through such
uninsured components as the physician's loss of time and reputation in defending a case. Thus, the increased frequency of claims may be evidence of the tort system functioning more not less efficiently in inducing optimal injury prevention. This efficiency conclusion is not unambiguous, however, because it ignores both the costs of "defensive medicine," defined as noncost justified precautionary practices induced by the threat of malpractice litigation, and the costs of operating the system.

With these caveats, the conclusion is that before abandoning the tort system, it is important to establish what changes in legal rules have induced the increase in claims, and whether they are likely to have moved us closer to the ideal of the tort system and hence should only be changed if the costs of litigation and defensive medicine outweigh the gains of inducing a more optimal standard of care. Professor Lewis ignores the possibility that the changes in the legal environment have been in the form of improving the efficiency of the tort system, and asserts a shift towards strict liability. He cites no evidence to support this thesis and to my knowledge, neither the requisite data nor the analysis exists.

As suggestive evidence to support the thesis of a shift to strict liability, Professor Lewis cites two phenomena of the development of medical technology, to include more procedures that are high risk in the sense of having great potential for bad as well as good results, and biased consumer expectations towards underestimating the chance of bad results. But more risky medical technology per se need not lead courts to a doctrine of strict liability or to any increase in claims under a negligence standard if physicians correctly perform the cost-benefit calculus required by the legal definition of negligence—that the expected benefits of the action outweigh the expected cost. The chance of doing the calculus correctly and hence avoiding conviction for negligence does not depend on the probability distribution of potential outcomes. In other words, what matters is that the potential outcomes and their associated probabilities be well known and agreed upon in the medical community, not the absolute magnitudes involved. If the probability distribution is not well known, however, then litigation will arise because different medical experts disagree on the expected outcome of performing a particular treatment and hence on whether or not it constituted negligence. Professor Lewis does not adopt this line of reasoning, from the increased riskiness of medicine to the increase in malpractice suits, in terms of medical uncertainty as to outcomes. On the contrary, he states that, "Most of the technical interventions that carry with them a real risk of morbidity or mortality are indicated, at least from the medical point of view."

As a second argument to support the thesis of a shift to strict liability, Professor Lewis claims that patients underestimate the risks
of bad outcomes, even if they are nominally informed, and that inflated expectations are a cause of the increase in litigation. However, the failure of medical practice to live up to patient expectations in itself cannot sustain an increase in malpractice litigation, without some endorsement from the courts. If the courts are adopting a strict cost-benefit negligence rule and there is little disagreement among medical experts, then no matter how disappointed the patient over a bad outcome resulting from a nonnegligent treatment, an attorney paid on a contingent fee basis will not accept a case that has little chance of winning.

To summarize, Professor Lewis attributes the increase in malpractice suits to a shift in legal doctrine from negligence toward strict liability in conjunction with increased riskiness of medical practice, and inflated patient expectations and dissatisfaction with care. It seems to me that he has not established any evidence of a doctrinal shift to strict liability as opposed to a decrease in the cost of proving negligence, or any logical connection between riskiness of practice or patient attitude and the sustained increased frequency of suits, in the absence of a doctrinal shift. The contribution of these factors to the increased frequency of suits therefore remains an empirical question that can only be answered by a study of actual claims and court decisions to determine why claims are more prevalent for high risk procedures, whether dispute centers round the medical estimate of the riskiness of the procedure or round quantifying the loss to the patient, and whether courts are still applying a negligence rule in determining liability. From the fact that premiums are highest for surgical specialties, we know that there is a correlation between claims and the riskiness of procedures, loosely defined. But it is not known whether this is because courts have moved to strict liability, or because physicians tend to underestimate the potential costs, hence perform actions that are "negligent" by the legal definition, or because it is simply easier to detect surgery-related injuries. I would be very interested in hearing the opinion of legal and medical experts here on the development of legal doctrine in this area and the nature of the mechanisms connecting risky procedures with high claims cost, hence high premiums.

The question of what fraction of current malpractice suits result from a shift to strict liability is of importance in assessing the likely effects of Professor Lewis' proposed solution, that physicians should exonerate themselves from liability for adverse outcomes arising from bad luck rather than negligence, i.e., from strict liability, by involving the patient in the decision to adopt a particular treatment, after conveying to the patient the necessary information on which to base a decision. Thus, a form of private contract would establish rights and responsibilities ex ante rather than the courts performing the same function ex post.

Such an attempt to assign rights by private contract ex ante would only eliminate those malpractice claims which are based on strict liability. The standard of care contracted for is likely to be precisely
the standard applied under negligence law, because the informed patient would be willing to pay for those precautionary measures with expected costs less than expected benefits. Claims would still be brought both on the grounds that the physician did not provide the agreed standard of care, i.e., that he was negligent, or on the grounds that he did not provide sufficient information to the patient, or that the patient was not in a fit state to use it. In fact, in an earlier part of the paper, Professor Lewis himself doubts that patients can bear the responsibility for decision-making at a time when they are necessarily incapacitated. Thus, from the point of view of reducing malpractice litigation, it is not clear to me how Professor Lewis' proposed solution would improve on the current situation, where physicians already require patients to sign statements indicating that they have been informed of possible adverse outcomes, as a defense against strict liability, but are still open to claims on the basis of negligence or that the consent was not truly informed.

Let us accept, however, for lack of evidence either way, Professor Lewis' assertion of a shift by the courts from a negligence standard for compensation to strict liability. He interprets this as "social irresponsibility" on the part of the legal profession, and blames it partly on "an environment where reinforcements are provided for the filing of claims essentially without risk to attorneys." Surely the essence of the contingent fee commonly used as opposed to a fixed fee form of contract is that the attorney assumes the risk of investing resources in a case and receiving no award. The attorney paid on a contingent basis will be more scrupulous in checking out the legal validity of a claim before accepting the case than if he were paid a fixed fee or hourly wage, regardless of the outcome of the suit. Moreover, the handling of malpractice on a contingent-fee basis predates the recent surge of litigation and is uniformly adopted in all states of the United States, so contingent fees cannot account for the change over time or the variation across states at any point in time in the volume of malpractice claims.

More generally, it seems to me that to assign blame to plaintiff attorneys for the current crisis is to misrepresent their role. They are merely agents for one party in a dispute over income distribution. Their role is to represent the interests of their client, and if they did not pursue these interests, the whole system of using the courts to resolve disputes in favor of the party that provides the most cogent case, within the defined rules, would cease to function. A stronger case could be made for assigning responsibility for the increased litigation to judges who ultimately determine the roles of liability, which in turn affect the volume of claims. However, whether a shift to a strict liability rule, if such has indeed occurred, constitutes "socially irresponsible" behavior, is extremely difficult to determine. There are two issues involved. The first is a normative question of income distribution: Who should pay for adverse medical outcomes, the unlucky
victims, physicians, or consumers of health care in general, to whom much of the resultant increase in premiums must be passed on? The second is a nonnormative question: Which liability rule produces the most efficient use of resources, i.e., minimizes the sum of the costs of accidents and the costs of accident prevention? To my knowledge the evidence has yet to be assembled which demonstrates the superiority, on the basis of social efficiency, of either strict liability or negligence liability.

Finally, I would like to add a brief comment on related themes we have heard several times today: Why, to quote Professor Lewis, "the science of diagnosis and cure has replaced the art of care," on the unwillingness of physicians to involve patients in decision-making; and the tendency to inflated expectations on the part of patients.

A simple model of human behavior used by economists, and one that has proved useful in a wide variety of contexts, postulates that people seek to maximize their income. From this perspective, what incentive does a physician have to provide care as opposed to diagnosis and cure? He is typically reimbursed on the basis of a fee schedule for various types of procedure, with limited potential for modification except in exceptionally complicated cases. Thus, the price of an office visit does not vary in proportion to the length of the visit or amount of sympathy shown. As in any piece rate system, the incentives are to minimize time input—and hence quality—and maximize numbers of units produced or, in this case, procedures performed. Similarly, the physicians' pecuniary incentives operate to minimize the amount of information on possible adverse outcomes he will give the patient. The more risky the patient perceives the treatment to be, the less likely he is to submit to it, and the lower the physician's income. Thus, medical education faces an uphill battle if it is to offset these features of the incentive structure that the physician faces when he goes into practice.
Discussion Following Lewis-Munch Presentations

The discussion following the Lewis-Munch presentations tended to veer in the direction of the complexity of many of the controversial factors connected with malpractice litigation. Although much of the discussion was lively, relatively few issues were raised that were directly relevant to medical education. It did confirm, however, at least in this audience, disagreement about which aspects of malpractice litigation -- changes in tort law doctrines, insurance practices, litigiousness of plaintiffs or their attorneys, the inadequacies of medical record keeping, the need for social insurance against nonrecovery with or without medical malpractice, etc. -- are the most important topics for analysis. After a lengthy but inconclusive interlude, the discussion returned to the topic of medical education.

With regard to the need for curriculum changes in medical schools, Dr. Marvin Gasster raised the issue of the medical schools' responsibility to study the subsequent professional development of their students in an effort to determine their performance as house officers during their internships and residencies. He noted the general failure of schools to perform this task. If curriculum changes are made by medical schools, an effort should be made to determine whether such changes have beneficial or harmful effects on their students' subsequent performances as physicians. Dr. Bernice Wenzel, who agreed with Dr. Gasster that most medical schools have not systematically studied the performance of their graduates, pointed out that the Association of American Medical Colleges is in the process of correlating a long range follow-up study (a 10-year review of several hundred graduates from a number of schools). However, this study is still in its early stages and it is too soon to determine what light it may shed on the direction medical education should take.

Dr. Lewis developed further his idea about the importance of studying and experimenting with the practice of assigning greater responsibility to patients for sharing in decision-making regarding their own medical care. For example, he pointed out that we need to explore the costs and benefits of giving patients access to their own medical records. Dr. Lewis also entered an interesting caveat regarding the inclusion of the patient in the process of health care decision-making. He noted that there may be many patients who, given the opportunity to choose between the authoritarian physician and one presenting them with options for their own health care, would choose the former. There are undoubtedly a number of people for whom this has a placebo effect; being in good hands may constitute a major part of the treatment.
However, to the extent that increasing patients' participation in and responsibility for their own medical care is desirable, physicians must be selected and trained partially on the basis of their ability to share such responsibilities with patients. To select and train the type of person who will be able, as a physician or other health care professional, to implement the biopsychosocial model, and to work in a nonauthoritarian way with patients, will be essential steps toward improving medical education and medical practice, and hence toward reducing the number of malpractice suits and the cost to the community of malpractice litigation.
SECTION III

RESPONSES
Dr. Gampell criticized the authoritarian atmosphere of most medical care, including his own medical education in England. He expressed his concern and desire that medical students be exposed to and be taught by clinicians who exemplify appropriate and good role models.

One aspect of medical practice that Dr. Gampell believed significantly contributes to medical malpractice is the exceedingly long working days put in by many physicians. He said that medical education indoctrinates physicians. After suffering the long hours of medical school, internship, and residency, a similar pattern becomes the routine for office practice. For example, to expect a physician to interact successfully with patients after being on call for many hours is wholly unrealistic. This problem can be only partially solved by increasing the number of available physicians. In addition, physicians must be taught to be sensitive to how their own personal physical limitations due to overwork, especially in high risk specialties, may impair their ability to provide careful and caring treatment.

Dr. Gampell next discussed a problem that arises in teaching and research hospitals. For purposes of teaching and research, patients are sometimes provided with a technical level of care that exceeds their therapeutic needs. Such patients are not always adequately advised of the risks and discomforts of such treatment. This is tantamount to medical experimentation without valid informed consent. Dr. Gampell illustrated this problem with a recently reported California Appellate Court case (in which he was involved as an attorney) in which a patient suffering from severe angina and claudication in the legs was subjected to numerous painful and risky tests for teaching and research purposes a year later. During the tests the patient suffered a stroke and was permanently incapacitated. Dr. Gampell raised the question whether the battery of tests were really done for the patient's benefit or for the benefit of the teachers and researchers. Dr. Gampell stressed that the rise of consumerism in medicine -- as in other fields -- has put pressure on the medical education community to analyze the value conflicts embedded in medical practice. Medical educators must respond by training medical students to acquire a greater appreciation of the social, legal, and ethical responsibilities that are attracted to and flow from their roles as physicians.

Dr. Gampell, currently Administrative Director of the California Courts, is a former President of the California State Bar Association, has practiced both medicine and law, and has lectured and written extensively in medical-legal fields.
Dr. Boyle reiterated Dr. Engel's concern that medical students receive more comprehensive scientific training and clinical experience to enable them to appreciate the psychosocial dimensions of disease. To reinforce this point Dr. Boyle indicated that one of the major sources of discontent among medical students is that they do not receive adequate training germane to patient care and patient satisfaction. Dr. Boyle gave several examples to illustrate his claim that lawsuits are often filed by patients who are dissatisfied with medical care even though they were not negligently treated. According to Dr. Boyle, the dissatisfaction arose because the treating physicians in the cases he described were insensitive to psychological dimensions of their patients' illnesses.

Dr. Boyle. a practitioner of Internal Medicine and Diseases of the Chest, is Speaker of the California Medical Association's House of Delegates.
Mr. Henning, Director of the American Bar Association's Division of Professional Education, has written articles for newspapers, magazines, and law journals on legal education and professional responsibility.
I am a lawyer and an educational administrator who occasionally does some teaching. I have never been involved as a lawyer or a patient in a medical malpractice matter. I know nothing whatsoever about medical education. Thus it is with some misgiving that I accepted the invitation to wrap up this conference with some reflections on these matters and an attempt to relate them to problems we face in the legal profession.

To begin, it is obvious that medical education and medical malpractice have at least one thing in common -- they are both means of assuring professional competence. Medical education helps students achieve a higher level of competence than they would otherwise, and measures the level of achievement by means of examinations. Education is a threshold means of measuring and screening competence, or an input measure, along with others such as licensure and accreditation standards. Medical malpractice is an attempt to measure and control competence after the fact, and could be called an output measure. The former measures competence by assessing knowledge, analytical ability, and clinical skills. The latter measures it by examining the results achieved in practice in the context of possible errors or omissions.

Let me suggest that neither of these measures has very much significance with regard to the over-arching problems in health care. They relate only to the quality of individual practitioners, not of the system. Neither tells us anything about what the purposes of the health care system could or should be. Taken together they are trivial influences on overall health care. If the challenge is to improve the health of the American people, we should be examining fundamental structural and economic issues in the health care professions, rather than curriculum or professional liability. I say this only to suggest that we must be modest in assuming the extent to which reforms in professional education or professional malpractice liability will raise the quality of health care delivery. Similarly, counterpart reforms in the legal profession would do little to improve the quality of the delivery of legal services.

In fact, it could be argued that professional education and professional malpractice liability may retard improvements in the health care system and support the status quo. In legal education (to argue by analogy to something I know a little bit about), it is very difficult to deal with the cutting edge of innovation which -- at the present time -- would include means of de-lawyering society, de-regulating industry, de-criminalizing victimless crime, and so on. Legal education concerns law as it is, for the most part. The legal curriculum tends to reinforce the current structure of the system and the profession. I wonder if there is a similar situation in medical education.
Malpractice cases are decided, like all legal cases, largely on the basis of historic standards, or precedent. In other words, doctors are held to a standard representing the traditional and customary approach to medicine. Thus the most innovative and creative procedures, which involve higher risks, more often may lead to an unfavorable result in treatment and subsequently in court.

These conservative elements in professional education and professional malpractice liability are not entirely unrelated to one another. Fear of liability, we all know, is encouraging the practice of defensive medicine. This ultimately will have an adverse impact on education. Good clinical education deals with the hard cases. In many instances, the hard cases are concluded with undesirable results. I have heard doctors say recently that they will never again order up an autopsy following an unexpected death for fear that the data may eventually end up in a court file. Thus medical research as well as teaching will be impoverished.

The cost in good data for research and education could be compensated by the social and professional benefits provided by liability cases themselves. One can imagine a rational system in which litigation concerning medical malpractice provided expert evidence and thoughtful opinions that could themselves be of value in medical education. Such a system would discourage professional negligence by offering examples of instances where skill and careful attention on the part of a doctor would have prevented a patient from getting worse or helped him get better.

The trend in malpractice litigation; however, may be toward a wholly different objective. In Clark v. Gibbons,* Justice Tobriner of the California Supreme Court said:

"The basic error lies in primary reliance upon the concept of negligence...the largely fictious and often futile search for fault...A system openly imposing liability without any pretense of negligence...can avoid unwarranted imputations of fault...Such a system can insure that the burdens of unexplained accidents will not fall primarily upon the helpless but will be borne instead by those best able to spread their cost among all who benefit from the surgical operations in which these misfortunes occur."

This notion of strict liability would, if played out to its logical conclusion, lead to a redistribution of the social costs of iatrogenic illness. This might be good or bad. But to the extent that judges and juries are expressly, implicitly or even subconsciously working toward this objective, medical malpractice litigation may throw the medical profession into chaos, because doctors will not know what is being expected of them by the legal system and how to conduct themselves to

* 66 Cal. 2d 399, 426 P. 2d 525 (1967)
to stay out of court.

Nor can the courts do a satisfactory job of redistributing these costs. As much as 80 percent of damage awards in medical malpractice is absorbed by the legal system, rather than the plaintiffs. And most cases don't even get into the system. Legitimate malpractice claims that are either too small or too esoteric have no access to the courts whatsoever. One hears that between two and four million iatrogenic injuries occur per year and the great majority go uncompensated. While the contingent fee system can hardly be blamed for the current malpractice crisis, it probably does discourage the great majority of potential claimants, whose maximum claims are too small to interest a lawyer.

Professor Richard Epstein of the University of Chicago Law School suggests that we have reached this sorry state of affairs in part because tort theory, upon which professional malpractice liability is based, does not adequately deal with the relationship between doctors and their patients.* The classic case of tort law involves a pedestrian hit by a car or a consumer injured by an exploding bottle of Pepsi. Strangers who have no prior relationship find themselves unavoidably drawn together in a lawsuit. In such situations, there are no alternatives to tort law.

As Dr. Lewis suggested in his paper and in his remarks, there is usually a voluntary relationship between a doctor and a patient. It is a consensual one that could give rise to affirmative rights and responsibilities on both sides. It would be possible in an expressly consensual relationship to agree to a standard of care and to the degree of risk involved in a given medical procedure. The doctrine of strict liability for satisfactory results would be affirmatively waived by the parties in advance.

There are some medical matters that are adequately resolved by conventional tort law. One example discussed earlier in this conference is an anesthesia procedure that goes wrong as a result of a mechanical malfunction. On the other hand, most complicated medical procedures to not lend themselves to easy resolution through tort law. A patient who chooses a doctor is hardly in the same relationship to him as the arbitrary victim of an automobile accident or an exploding bottle of cola. Perhaps a suit in negligence is not the best answer in social terms for the resolution of claims resulting from the typical doctor-patient relationship. In such cases, contract law based on express consensual relations may well provide more rational decisions. Fabricating techniques for moving malpractice cases into contract law will not be easy. Malpractice matters usually involve not two parties, but many, including several doctors, insurers, co-insurers and often hospitals as well.

In a malpractice system based on contract law, cases like the recent Helling v. Carey* in the state of Washington would be avoided. In this case, a 32-year-old woman suffered permanent eye damage from angle glaucoma. For ten years prior to the diagnosis, the patient's ophthalmologist did not administer pressure tests for glaucoma, because it was not the custom to do so on patients under the age of forty. Statistically, only one person in 25,000 under the age of forty was known to contract angle glaucoma.

Nevertheless, the Supreme Court of the State of Washington held, as a matter of law, that the doctor was liable. Even though it wasn't a custom, the court reasoned, the doctor ought to have administered the tests. This theory of strict liability has precedent in other fields of tort law. It is known as the T. J. Hooper doctrine. In the famous T. J. Hooper case, Judge Learned Hand held that the custom or practice in the trade was irrelevant if a higher standard of care was possible.**

The T. J. Hooper was an admiralty case involving a boat that went down in a storm. If there had been a radio aboard, the crew would have heard a weather forecast and the tugboat could have avoided the storm. Radios had been invented but were not at the time customarily carried by tugboats in that area. The judge said that it was a matter of no consequence whether anybody else carried such a radio, everyone should have. Judge Hand said that a calling:

"never may set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission."***

This may be the trend in medical malpractice. Here a learned profession is being second-guessed by members of another rather different profession who happen to wear robes and sit in judgment. It is confusing in view of the fact that it may be in some cases that these judges and juries are applying a cost-benefit analysis to the situation rather than merely finding facts and applying the law.

In the T. J. Hooper context and in the classic tort context, the issues involve harm done by one stranger to another. Strict liability in such situations may make sense. In a consensual relationship be-

* 83 Wash. 2d 514, 519 P. 2d 981 (1974)

** The T. J. Hooper, 60 F. 2d 737 (2d Cir. 1932).

*** Id at 740.
tween a professional such as a doctor and his patient, it may make less sense. In a consensual relationship, custom should prevail unless it is displaced by specific contractual arrangement. What we may have is a struggle between the professions of law and medicine over jurisdiction to set standards of care in the medical profession, complicated by a sense of social injustice concerning the unredistributed costs of iatrogenic illness.

The most extreme implications of this trend are visible in the case of Gail Kalmovitz.* In 1953, she was born prematurely, and treated with large doses of oxygen, a common procedure at that time. This procedure caused retrolental fibroplasia, a severe visual impairment. Much later the side effects were linked to the treatment and she sued. Recently a New York jury was prepared to award her $900,000, moments after she settled for $165,000. In this case, had it gone to judgment and been upheld on appeal, the doctors would have been held retrospectively accountable for side effects unknown at the time.

Of course strict liability and the T. J. Hooper doctrine have hardly become the rule nationally in medical malpractice cases. However if such a trend were to set in, the ultimate impact on medical education would be enormous. The law, which is of little value if it is not predictable, will rightly be scorned by doctors who will find it impossible to evaluate risks based upon their professional conduct. And there is little likelihood of doctors and medical educators discussing what went wrong and how it came to go wrong if by doing so they may be increasing their exposure to malpractice claims.

I was struck in listening to Dr. Engel's remarks at how difficult it would be to implement his proposed reforms in medical education -- a return to scientific method and a rejection of dogmatic application of the biomedical model -- under the doctrine of strict liability in medical malpractice. In fact, I cannot imagine an education, however excellent, that can prepare a doctor to survive in such a malpractice system.

To defend the legal profession, and the judges and juries in particular, for a moment, however, one must remember that courts in the United States have for a generation truly been the last resort of those unable to find justice elsewhere. Perhaps in moving toward strict liability in medical malpractice, the courts are attempting to deal on an ad hoc basis with problems that should have been dealt with long since by the medical profession or the Congress -- questions of cost control, national health insurance, patients rights, and so on.

The problem of our decaying inner cities is in some ways perhaps analogous. For years our leadership allowed segregated housing patterns, job discrimination and other gross inequalities to survive until, finally,

* Newsweek, April 7, 1975, at 49.
the United States Supreme Court was compelled to attempt a highly imperfect solution to the problem in one of the few ways open to it, by ordering the busing of public school students.

There the courts found themselves addressing social problems involving the whole complexity of society, but could only decide individual cases involving very specific and idiosyncratic problems. The courts should not have to solve such problems, but other institutions failed. Similarly, perhaps the medical profession and the political system delayed action too long and the courts now inexorably if imperfectly are attempting to compensate for these failures.

It is important to remember that the courts do not get into these no-win political issues on their own initiative. Cases only come before the courts when parties bring them. People with grievances come seeking specific remedies. The courts are to a very large extent compelled to act.

In conclusion, let me now turn to some random reflections on how our two professions compare. If, as several here have commented, medicine is constrained by dogmatic adherence to the biomedical model, it could be argued that law is similarly constricted by religious worship of the adversary model. I do not mean to imply that the adversary model ought to be scrapped entirely. It is often essential, as in the case of the infamous Saturday Night Massacre. When Richard Nixon fired the special prosecutor, Archibald Cox, he was attempting to destroy the adversarial relationship between a prosecutor and a potential defendant in a context where it was absolutely essential.

On the other hand, there are many areas of law where the adversarial model is applied and the results are less than ideal. For example, TV broadcast licenses are awarded and renewed by the Federal Communications Commission in an adversarial proceeding. Other administrative agencies, which ought to operate on a model of administrative or distributive justice, instead operate on a model of retributive justice determined in adversarial proceedings.

As I already mentioned, judges are often given to the resolution of complex social policy issues in the context of the adversarial system. As we have seen, this may be happening in medical malpractice cases, where the doctrine of strict liability may be applied as a "cover" for the fabrication of a system of social insurance.

If there are similarities in the way our professions tend relentlessly to apply the traditional models, there are enormous differences in education in our two professions. Whatever faults you in medicine may find with medical education, you cannot argue one essential point -- money. Because of the availability of substantial governmental support
for medical education, it is truly a professional education with substantial amounts of research undertaken and clinical study provided. On the other hand, legal education is virtually unsupported by any source other than tuition. Law schools do little more than provide students with another undergraduate education. There is virtually no attempt to provide in-depth sequential curriculum in legal specialties. There is very little clinical education which, as you know, is quite expensive. The average law school student-faculty ratio is 35 to one, which means that virtually all law school courses are survey courses, similar to undergraduate courses. Finally, virtually no funds are available for empirical research.

Perhaps the two professions are so far apart educationally in part because of the Flexner Report. Whatever faults may have been found with that report prepared in 1910, I am sorry to say that no in-depth study of the structure of legal education has ever been undertaken.

Although it comes under attack on occasion, the best thing about legal education is the case method. It, of course, depends for its effectiveness on the same adversarial model that I just criticized. The case method provides law students with a vehicle for learning how to handle ambiguity and complexity in a manner that many of you have said at this conference is not provided to medical students. Law students are constantly exposed to issues that involve various shades of gray rather than black and white. The law mainly involves conflicts between rights and rights rather than rights and wrongs as, for example, in the conflict between the constitutional right to freedom of speech and the guarantee of a fair trial.

I think also that the legal profession has emphasized preventive practice more than the medical profession -- at least for the wealthy client. Rewards and status are greatest in the legal profession for corporate lawyers whose practice to a very large extent involves the avoidance of disputes and the structuring of transactions to be immune from later misunderstandings and conflicts. Some of you have criticized the lack of medical training in the interviewing of patients. Somehow, lawyers seem to do better in this regard, in part perhaps because of the kind of education that they receive, although client interviewing is only recently becoming a specific subject in the curriculum.

Turning to the problem of professional malpractice, I can report that you may take consolation in the fact that lawyers are being sued -- and losing -- more often than ever. Malpractice insurance premiums have risen significantly in the legal profession and the problem is now on the agenda of all bar associations, but it will never approach the dimensions of the problems in medicine. First of all, the legal industry is simply not as big as the medical industry. More than 8 percent of the gross national product is devoted to health care. Substantially less than 1 percent is devoted to legal services. Second and more important, lawyers do not injure, maim or kill their clients.
Lawyers are largely protected by the fact that they work with paper rather than human tissue. When a doctor makes a mistake with human tissue, it is hard to hide. Lawyers' mistakes are most often hidden forever in file drawers.

Also, the role of the doctor is perceived as clear and simple—they make patients well. Legal clients do not hold so simple a notion of the role of the lawyer in achieving desired outcomes, and even the outcomes themselves are more ambiguous. In the context of litigation, lawyers are part of a process where others—judges and juries—are primarily responsible for the outcome. In the contest of corporate law, the lawyer's role is often to advise his client as to the relative degrees of risk that various courses of conduct involve. Responsibility for choosing a course of conduct falls on the client, not the lawyer. This explains the traditional story about the lawyer asked by his friend, "Why do lawyers always answer questions with questions?" The lawyer answers, "We do?"

While doctors are still revered by many who see them as healers, lawyers are often seen as equivocators and agents of the devil. Doctors are there to cure the afflicted. Lawyers defend the innocent and bring the guilty to justice, but they also defend the guilty and prosecute the innocent. In civil matters they protect the downtrodden, but they also help the rich get richer.

Perhaps the perceptions in the minds of the laity concerning both of our professions can be given added dimension. Perhaps we can do something to educate the general public as to the potential and—more important—the limitations of medicine and law. Public education, systematic development of solid curricula in the schools and the colleges, might help. The American Bar Association has for several years been involved in law-related education, and more than 600 projects involving cooperation between the organized bar and educational authorities are operating throughout the country's school system. Contrary to previous efforts at law-related civic education which often involved no more than a public relations program and raised false expectations as to the potential of the legal system and lawyers, the curriculum currently being developed includes the training of teachers in Socratic and case method to teach law in a relatively subtle and sophisticated manner. Perhaps similar programs could be developed in your field.

I have often been asked lately to think about how professional competence can be measured and maintained. Perhaps the final answer is that education and professional malpractice liability cannot have as much impact on competence as improved standards of admission to our professional schools. Perhaps the best answer is to bring in persons at the threshold whose ethical as well as intellectual reasoning abilities are more highly developed. I am reminded of what Lester Maddox said when the subject of prison reform came up during his tenure as Governor of Georgia. He said, "We've gone about as far as we can to reform the prisons until we get a better class of prisoner."
The specific topic of medical education and malpractice litigation is only one aspect of the general topic of professional responsibility of health care professionals. Many questions raised and discussed at this conference have implications for professional education not only in medicine but also in law and other fields. Some of these questions include the following:

1. How is professional competence acquired, evaluated, and reinforced?
2. How is professional competence related to patient or client satisfaction?
3. To what extent do professional role models, such as the biomedical model in medicine, or the adversary model in law, affect professional competence or consumer satisfaction?
4. How can professional responsibility be taught in professional education and reinforced in professional practice?
5. Do consumers have unreasonable expectations about the costs and benefits of professional services?
6. Should the rights and responsibilities of professionals and their clients be allocated differently? How will such changes affect the quality of professional services or consumer satisfaction?

As the proceedings of the conference illustrate, considerable disagreement arose concerning the answers to such questions in the context of medical education. But there was substantial agreement that the issues are ripe for reexamination.

A. Conceptual Foundations. One important conceptual issue raised at the conference was the definition of the physician's role, including not only scientific but also social and ethical features, as well as the rights and responsibilities contained in and implied by proposed definitions. It was agreed that medical education must be sensitive to the current reexamination of the basis of physicians' professional responsibilities. Certain issues were clarified and topics for further discussion were identified. These include the following:

1. Are the psychosocial dimensions of medicine susceptible to scientific study and to scientific practice?
2. If so, how can associated skills be taught to health professional students? If not, how are the psychosocial aspects of medical care to be taken into consideration in medical care?
3. How should the rights and responsibilities of physicians and patients be redefined to allocate greater responsibilities to patients for their own medical care?

Although these conceptual problems are not new, and the disputes they engender are not easily resolved, it is important that such issues become integrated with other aspects of medical education to help professionals with an appreciation of the ambiguities and the controversial aspects of their professional roles.
B. Value Assumptions. Closely connected to the conceptual questions are assumptions about basic values. Dr. Engel emphasized the importance of bringing scientific knowledge and skills to bear on the psychosocial aspects of medical care. Dr. Shuman expressed concern that physicians—as well as other scientists—tend to exaggerate the power of science and, as a result, assume responsibilities beyond the scope of their competence. Dr. Lewis took the position that by failing to respect the rights of, and assign responsibilities to patients, physicians may arouse mistaken expectations and increase dissatisfaction among patients. The value of making the patient a more active participant in his or her own medical care is that it respects the patient's autonomy and increases the likelihood of satisfactory treatment through patient compliance.

C. Empirical Hypotheses. Dr. Engel is convinced, after years of teaching and research, that the psychosocial dimensions of medical care can be scientifically studied and taught. However, empirical data, apart from clinical anecdotes, that would confirm or disconfirm his hypothesis have not been systematically assessed. Empirical research on patient participation in their own health care is being gathered by Dr. Lewis and his associates at the Center for Health Sciences Research at UCLA. Another relevant issue—the relation of patient satisfaction to medical malpractice litigation—has not, to our knowledge, been adequately studied despite frequent speculations about it in the medico-legal literature. Joel F. Henning's observations concerning the differences between medical and legal professional education also warrant further empirical study.

D. Medical Education and Professional Responsibility

It is surprising that so little systematic attention has been given to teaching of professional responsibility until very recently. And despite the voluminous literature of "bioethics," the need for further analysis of conceptual, valutational, empirical, and practical issues has not yet been met. Physicians, attorneys, and other professionals have often been in conflict with one another with regard to professional conduct but have rarely sought to cooperate with each other in seeking solutions to their common problems.

One reason for this is that physicians and attorneys have traditionally viewed each other with suspicion if not distrust. Those physicians who encounter lawyers in malpractice cases often focus attention on the weaknesses and unpleasant aspects of the adversary system and its participants. Those attorneys who confront physicians in medical malpractice lawsuits have a tendency to make hasty generalizations about the incompetence of health care personnel. This tension is increased by the public's fear that both professions are at least greedy if not unscrupulous. Of course there is much more to the picture: practitioners of law and medicine who are competent, cooperative, and unselfish, professionals who have a heightened sense of duty to the public, and active critics within the professions of their unethical colleagues. But failures and flaws that produce pain and suffering are more often noticed than the successes and skills that prevent them. Moreover, the services of physicians and attorneys
are typically sought only after something has gone wrong—a person becomes ill or a legal crisis occurs. Physicians and attorneys, despite talk about preventive medicine and preventive law, are often remembered in connection with unhappy events in one's life. Too little attention is given to those aspects of law and medicine that preserve and promote individual health and facilitate interpersonal interaction.

Among the many reasons why these partial perspectives have become stereotypical images of the professions of law and medicine, perhaps the most prominent is that the educational system in general, and professional education in particular, has neglected several important responsibilities. Preprofessional education in medicine and, perhaps to a lesser extent in law, is oriented toward admission to professional schools. Little attention in undergraduate education has been given to the study of the nature of professional activity as preparation for becoming a sensitive and responsible professional person. Even less interest has been shown in educating students who do not desire to enter professional schools about individual or social aspects of the health or legal professions. This neglect has helped to perpetuate the well-established public stereotypes of attorneys and physicians. Nevertheless, such stereotypes, however distorted and incomplete are the pictures they present, have some truth to them. Educational neglect contributes to the failure to bring about the reform necessary to decrease the unprofessional practices that generate the stereotypes.

Educational neglect is nowhere more evident than in professional education itself. Despite a long tradition of lip service to education in professional responsibility in legal education, for example, it is rare for law schools to take this aspect of legal education seriously. A required course or a multiple-choice bar examination on professional responsibility is a token gesture; a critical, reflective attitude toward both the strengths and weaknesses of, for example the adversary system is not commonly cultivated in legal education. Instead, most law students are indoctrinated about the value of adversarial thinking; a few will seek clinical training to acquire adversarial skills; but even fewer are taught to be reflective about the scope and especially the limits of the adversary method. The basic assumptions that enter into and guide the professional activity of most attorneys are rarely articulated, much less systematically studied in law school or, for that matter anywhere else.

If the study of professional responsibility is neglected in legal education, it is also disregarded in medical education. Physicians are taught how the scientific method applies to medical practice. But little, if any, attention is given to training physicians or other health professionals to act responsibly in carrying out the nonmedical aspects of their professional roles. It is often assumed that physicians have already received their training in ethics or social responsibility prior to medical school. If not, then it is tacitly assumed that knowledge about and skill in coping with the human value dimension of medical care will be acquired through imitation of clinical teachers who provide role
models. Even though role modeling is one important source of knowledge, it is obvious that it is insufficient to carry the entire burden. The recent rise of interest in "bioethics" comes not only from the critics outside the health professions but also from the questions of troubled students, teachers, and clinicians who feel the pressures and frustrations produced by ethical and social conundrums that repeatedly arise in health care.

There are many ways to respond to the need for more analysis, discussion, and training relevant to theoretical and practical aspects of professional responsibility. Lectures, symposia, courses, research, publications, and all the standard methods of education and training are a minimum requirement. This means that courses must be taught that go beyond usual disciplinary boundaries into less well-charted territory. For example, tort law students and professors must not only mention in passing but attempt to critically analyze assumptions about the purposes and actual results achieved by the tort law system. Such reflection, it is hoped, might have an important effect upon both new social policies as well as individual practices. To take an example from medicine, physicians must go beyond questions of the technology for providing care of the dying patient. It is necessary to give thought to the psychological, ethical, legal, and social aspects of such care and how they do and should affect one's role and responsibility as a physician.

Furthermore, unless the complex issues connected with professional competence, professional responsibility, and social accountability are taken seriously in professional education by faculty, students will be unlikely to obtain the knowledge and experiences they need. For unless the attitudes of educators of professionals as well as existing practitioners are modified, students will not get the reinforcement necessary in their struggle to work through the elusive and enigmatic human value problems that arise in law and medicine.

Thus the editors believe that topics such as those discussed in this volume must be analyzed at various stages of the educational process. The same issues might be profitably discussed in undergraduate, graduate, professional, postgraduate, and continuing education. As a person acquires greater knowledge and more experiences, his or her attitudes and conditions tend to change. It is desirable, however, that such change occur as a result of rational reflection on theoretical issues as well as on specific clinical experiences. Unless such reflection is encouraged and reinforced, especially in university settings, it is unlikely that the conceptual, valuational, empirical, and practical problems of professional judgment in law and medicine will be resolved in a manner responsive to human needs and human rights. What we have learned from the so-called medical malpractice crisis is that more thought must be given to redefining positive standards of professional competence and the broader policies of professional responsibility.
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