I am conscious of an elementary rule for lawyers appearing before the United States Supreme Court: "Explain how you got there." You are entitled to a similar explanation from me. Our Chairman is my physician. When he invited me to speak to you, I remembered that he once had made a house call on me—the only time, in fact, that I had asked him to do so. Plainly, I had to treat his invitation as a command.

When I asked him how I should carry out my assignment tonight, he was kind enough to give an intelligible prescription. First, he said, avoid clichés and, second, be brief. At first blush, his advice seemed admirable, but a more thorough examination turned up several problems. First, the avoidance of clichés on an occasion such as this might involve a massive culture shock, too severe for graduates exhausted by the rigours of examinations, even under a pass-fail system, and too severe also for their families exhausted by the financial demands of professional education. As for brevity, the notion of demonstrating that a lawyer could be brief tempted me, but only for an instant. I was saved from a commitment to such unprofessional conduct by my memories of waiting in physicians' ante-rooms, crowded with patients, whose number suggested to the uninitiated that the doctor needed visible demonstration that he was loved or that he was indifferent to the value of anyone else's time. As a result, my visions of sweet revenge are doing battle with your Chairman's suggestion of brevity. How it will all come out, only time will tell.

I propose to say a word, first, about the purpose of law as it impinges on the discharge of your professional responsibilities and, second, about the changes in our culture that underscore the need for reciprocal understanding and cooperation between our professions, among others. I must begin with a caution and a disclaimer. My own professional interests are remote from some aspects of matters, such as malpractice litigation, which, I understand, stir your interest and, from time to time, your sense of outrage. This caution is related to my disclaimer: What I shall have to say is not intended to be legal advice, and if you should decide to bring a malpractice suit against me, it would, I believe, be dismissed on the ground that your reliance on my remarks as a basis for action, rather than reflection, would be wholly unwarranted.

The essential enterprise of law is to subject men to the governance of externally imposed rules. In an ancient and celebrated declaration, which we have special reason to recall at this melancholy moment of our history, Lord Coke advised the King of England that even the Crown was subordinate to God and the Law. And so it is, I need not remind you, with the medical profession, which is increas-

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*Bernard D. Meltzer, James Parker Hall Professor of Law, delivered this paper at a meeting of the University of Chicago Medical Alumni on June 7, 1973.*
ingly entangled in a web of law, enforced by an uncongenial system of reparations and penalties.

The operation of that system in medical malpractice cases has spawned a cluster of problems that were said to be so profound by President Nixon that he directed that a Commission be established to deal with them. That Commission, established in 1971, filed its report in 1973.* I will draw on some of the findings of that report as I attempt to provide some perspective for the web of legal, medical, economic, sociological and psychological factors that make up the malpractice problem.

Although I don't want to be unlawyerlike by failing to emphasize the gloomiest contingencies, I venture to say that fears of legal liability expressed by some competent doctors seem extravagant to me. Thus, the Commission's statistics, although they indicate that the tempo of malpractice litigation has been increasing, also indicate that the risk of exposure for physicians as a group is relatively low. I recognize that "relatively low" are weasel words and that it is a human failing to minimize the risks that others bear. Nevertheless, you may find one of the Commission's statistics interesting, i.e., on the basis of the claim experience reported in 1970, there is less than one chance in 100,000 of an incident occurring that will give rise to a medical malpractice suit each time a doctor or a dentist treats a patient. This figure is obviously quite crude; it assumes that the incidence of malpractice claims is a matter of chance. It does not purport to reflect the disproportionately higher risk borne by surgeons and anesthesiologists, among other important variables. Nevertheless, some of you may get some comfort from the crude figure I just mentioned.

There is one situation in which fears of liability seem plainly to be exaggerated and may be a rationalization for other concerns. I refer to the Good Samaritan situation, the rendering of emergency aid by a physician who happens to see an accident. The Commission stated that there was no officially reported decision in which a physician had been sued for his efforts under those conditions; except for one case recently filed in Hawaii, which incidentally has a good Samaritan statute; it also reported that it had no information on unreported cases or settlements. Finally, the Commission reported that 50% of a group of physicians recently responding to an AMA poll indicated that they would not render emergency care regardless of whether a statute protecting good samaritans was in effect. I am skeptical that that poll is a reliable indicator of what doctors would do in a crunch.

In any event, the Commission's findings suggest that neither the actual nor the anticipated incidence of litigation explains whatever reluctance there is among doctors to serve as good samaritans. Crime in the streets is probably a much more important factor than the law in the books or the law in action.

Whatever the magnitude of the risk imposed by the law, it is a familiar argument that the doctor's plight is essentially the same as that of other citizens, who are increasingly subject to regulation, and that doctors, like others, can protect themselves by insurance at a price, and thereby shift the risk of liability, and through the pricing mechanism can distribute most of the costs of insurance to the consumers of medical services and third party payors. These points are, I believe, valid but not unqualifiedly so.

Insurance, while it can protect against direct financial losses, cannot protect against more subtle but quite important threats posed by malpractice litigation. Insurance plainly cannot protect against the wound to one's sense of competence and dedication or to one's name; nor can it protect against the undermining of that peculiarly important ingredient of treatment—confidence in the medical profession—or against the diversion of energy for depositions and court appearances in the demeaning adversary environment of a trial. It is understandable, although deplorable, in my view, that Dr. Northrop, a member of the Commission, reacted to malpractice litigation with this prescription: "Practice defensive medicine. And above all, and this is the most important thing, despise what could and should be honored, jurisprudence."

I shall return to this comment about jurisprudence in a moment. What is of more fundamental importance to the quality and availability of medical care is the doctor's exhortation to practice "defensive medicine." Defensive medicine in this context calls for some definition. Let me use the Commission's, that is, "the alteration of modes of medical practice, induced by the threat of liability, for the

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principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted." The Commission broke down this definition into two subgroups, "Positive defensive medicine," it added, "is engaging in a test or other diagnostic or therapeutic procedure which is not medically justified, for the sole or primary purpose of preventing or defending against the threat of Liability." And "negative defensive medicine" is the failure to take steps because of litigation considerations even though such steps are likely to benefit the patient.

The Commission referred to various opinion surveys that indicated that 50% to 70% of the physicians polled said that they engage in defensive medicine. It is not, however, clear that the pollsters used the same definition as did the Commission. In any case, the Commission found that the extent to which defensive medicine is practiced is unknown. The Commission did not, however, specify with any particularity the medically unwarranted action that would be a shield against liability, and as to some exposed specialties, such as anesthesiology, it is hard for an outsider like me to guess what they would be.

The Commission did suggest, although somewhat delicately, that ethical questions were raised by the practice of defensive medicine. Plainly, positive defensive medicine involves over-utilization of health care facilities and strains the resources of medical delivery systems and of patients. And negative defensive medicine may lead doctors to play it safe because of remote and insurable legal risks even though immediate medical considerations may call for bold innovation.

I do not mean to underestimate the instinct for self-preservation or to presume to be your moral tutor. But I cannot refrain from raising the question of whether defensive medicine as defined by the Commission does not deserve unequivocal professional condemnation.

The answer implied by the Commission is that such condemnation would be a futile gesture unless it were coupled with a reform of the abuses inherent in our liability system. That answer is, in my view, unacceptable, first, because abuses in the legal system do not warrant treatment designed to protect the doctor and, second, no matter what changes are made in our earthly legal system it will remain imperfect.

I do not mean to suggest that lawyers, or doctors, or citizens generally, should be complacent about the defects in our legal system. Plainly, our professions, severally and jointly, must work harder in the interest of reform. And, I would add, my colleagues have not been idle. This is not the place to assess their efforts, to appraise alternatives to existing standards of liability and damages, or to recite the difficulties of achieving the political consensus which is the prerequisite for legislative reform. But it is, I believe, appropriate to remind you that the law has as its ideal rational standards of performance and accountability, that it looks for such standards wherever it can find them, and that law-making institutions—courts as well as legislatures—will give weight to the judgment, experience, and integrity of doctors.

The law must, however, resolve conflicting claims and values. And so doctors, like others, may be heard but not heeded by the law’s institutions. But, contrary to Dr. Northrop, I urge you not to despise jurisprudence but to care for it enough to help improve it. The alternative to jurisprudence, as the doctor used that term, has, after all, been the fist and the club and modern improvements thereon. And the consequence of following his prescription would be a less informed law and a law that would stumble even more than it does as it seeks to do justice in the particular case and as it calls on all of us to remedy our defects and to be accountable for our lapses from governing standards of performance.

I do not, of course, mean to suggest that medical diatribes against the law are based on the premise that doctors should be exempt from appropriate standards of accountability or, indeed, on dissatisfaction with the content of existing standards as abstractions. My impression is that the procedures of the law are a more important source of inter-professional antagonism. It is true that those procedures sometimes are abused by unscrupulous lawyers and badly managed by incompetent judges. But the sources of antagonism are deeper than what I will loosely call the malpractices of my own profession and appear to involve differences in training and in working habits and insufficient understanding of those differences. That essentially psychological explanation has been offered by David Louisell, a law professor, and Harold Williams, a doctor and a
lawyer, in their work on *Medical Malpractice*. Referring to organized and interprofessional antagonism, the authors say:

The professional education, training, and habits of thought of lawyers and physicians profoundly differ. The modern law curriculum is essentially a continuing Socratic dialogue. Medical instruction is largely didactic and authoritative. Perhaps the reasons for this largely inhere in the nature of medical education, although one may question whether its techniques are excessively dogmatic. The controversial method is the meat of the lawyer not only because he functions in an adversary system but because he has been nurtured in controversy from his first day in law school. The physician on the other hand has been conditioned to objective scientific inquiry and to him notorious contest, with its emotional overtones, is apt to be a disruptive element in the search for facts. While the lawyer typically sees challenge in open disputation, the physician may see in it only unnecessary insult, especially when his own or a brother physician’s treatment of a patient is called into question.

Moreover, the nature of the lawyer’s everyday problem is akin to his conditioning and temperament. Of course, the trial lawyer functions in the heart-land of notorious controversy. But even the office lawyer in drafting a contract . . . knows that over his shoulder are peering the critical eyes of the lawyers for the other parties, actual or potential, to the transaction. Many physicians, on the other hand, are likely to think of their contacts with other physicians over a mutual patient as ideally constituting a cooperative effort directed toward the single objective of the patient’s health. Such physicians feel that although sometimes differences of professional opinion will unfortunately erupt into adversary disputation, usually they should be resolved harmoniously by mutual and objective inquiry and assessment. In any event, normally these differences are to be kept under cover for there is nothing quite so disconcerting to a patient as a dilemma about which of several attending physicians to believe . . .

As Louisell and Williams recognize, their observations can easily be pushed too far. Lawyers are not always at their adversaries’ throats; on the contrary, they accomplish a good deal of constructive problem-solving as adversaries. Furthermore, lawyers no less than doctors are troubled by aspects of our adversary process: our mysterious rules of evidence that exclude much that is relevant and stifle natural communication, the fallibility of human observation and memory, the conscious or unconscious distortion of partisan-witnesses, expert and amateur alike, the countervailing hyperbole of counsel, the vagaries of juries, the inadequacies of some judges, the need to decide one way or the other no matter what the doubts. These characteristics of litigation moved Learned Hand, one of our most respected judges, to say that next to illness and death he most feared to be a participant in litigation.

It is not surprising, then, that the doctor-defendant or witness in this alien, hostile and sometimes rude forum should feel antipathy for the lawyer who is cross examining him and for the system that subjects him to the ordeal of trial or cross-examination. Perhaps that antipathy will be reduced if physicians reflect on two points. First, the adversary method is the lawyer’s basic technique, which he is duty bound to employ in the interests of his client. The individual lawyer who discharges his professional obligation through the use of that method is no more to be blamed for the pain that he causes in dealing with disputes than is the doctor for the pain involved in dealing with disease. Second, the adversary method, like other kinds of strong medicine, appears to work reasonably well in resolving conflict. At least, we have not been able to devise a basic procedure more acceptable to a society, with our history and values.

At the same time, let me assure you, the procedural rules are subject to unending scrutiny and continuing reforms, some of which have indeed made inroads on the adversary system. Thus, with the cooperation of the medical profession, impartial medical testimony plans have been established with a view to curbing or neutralizing partisanship of experts in personal injury cases. Similar panels have been established for medical malpractice cases, thereby overcoming what used to be viewed as a medical conspiracy to cover up medical errors. Further development of such panels promises to promote interprofessional confidence and rapport.
as well as justice. In addition, psychiatrists, among others, have submitted useful and influential criticism of the legal criteria and procedures for dealing with issues of insanity and criminal responsibility. These examples make it plain that many physicians and lawyers have narrowed the interprofessional gulf and have engaged in fruitful collaboration.

There is another set of issues that call for such collaboration and that are, I believe, even more complex and more significant in their moral implications than malpractice and procedural problems. These issues arise from the achievements of medicine in prolonging life, from the new biology, and from the new morality that has sought to fill the vacuum left by the erosion of religious faiths. These issues include definitions of life and death in, for example, the context of abortion or organ transplants. They include questions as to the sanctity of life and the freedom of the individual in the context of euthanasia, eugenics, genetic manipulation or improvement, sterilization, and population control. There are, of course, other important public issues of a different order, such as those arising from proposals for the financing of medical care for the medically indigent and the related problems of adequate supply and delivery systems, and the protection of professional autonomy against the long and distorting reach of government. I also have in mind the housekeeping and financial issues created by new bureaucracies, whose demands for paper work proceed at a gallop while their payouts crawl.

I do not mean to suggest that law and medicine have the answers for all these prickly matters, many of which call also for insights of theologians and philosophers. But I do not know of any other professions who are closer to the light or whose large-minded collaboration promises to be more productive.

It would be natural and justifiable if many of you gave those large issues considerably lower priorities than the immediate demands of the surgical table, the laboratory or the consultation room. But others among you will no doubt see that those immediate demands cannot in the end be sealed off from what I have for convenience called public issues and that those issues in their own right merit your attention. In any case, I am confident that the necessary interprofessional cooperation, which has already begun, will continue and grow stronger.

My confidence is, let me emphasize, not occasioned by the need for a happy ending on an occasion such as this, but rather by the fact that the differences between our professions are, in my view, overshadowed by the attributes, the responsibilities, the pressures that, I like to believe, we have in common. Both professions call for intellectual and moral capacities of a high order, the resiliency to accept defeat, frustration and the deferral of satisfaction. Both of our professions are also increasingly fragmented by specialties producing a torrent of literature that threatens the whole man, in both his professional and human capacity. Both of them involve the tensions between cupidity and professionalism inherent in fee-for-service arrangements. Both of them also call for disciplined sensitivity to the grubby particulars of circumstantial evidence. And they call also for the management of doubt with respect to the most vital interests of those who depend on us. Both of them, in demanding the most exacting loyalty to those interests, reflect the basic commitment of our society to the dignity and freedom of the individual. Finally, for the proper discharge of our respective responsibilities, the admonition of my late colleague, Karl Llewellyn, is in point. Technique without ideals, he said, is a menace, but ideals without technique are a mess.

You may have caught an echo of the Hippocratic Oath in Llewellyn's comment. Let me draw from that Oath my wish and, I take it, everyone's wish for the Class of 1973, that you meet the demands of competence and integrity and enjoy "life and art"—notwithstanding the "brooding omnipresence" of the law.