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To Tell the Truth: Physicians' Duty to Disclose Medical Mistakes

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INTRODUCTION

Developments in tort theory and practice, including the establishment of national standards for specialists, the creation of common knowledge exceptions, and the use of res ipsa loquitur, have done much to overcome the "wall of silence" that once made medical malpractice actions such high-risk, low-gain efforts.[1] Plaintiffs may now avoid nonsuits by using medical experts drawn from outside the locality,[2] dispense with expert testimony altogether in certain cases,[3] and shift the burden of proof to the defendant once certain evidence is shown.[4] At the same time, the patient-consumer movement has helped to dispel feelings of de-

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1. For discussions of the "wall of silence" problem, see Kelner, *The Silent Doctors—The Conspiracy of Silence*, 5 U. RICH. L. REV. 119 (1970); Spence, *The Adverse Witness Rule: A Cure for a Conspiracy*, 23 U. MIAMI L. REV. 1 (1968); Note, *Overcoming the "Conspiracy of Silence": Statutory and Common-Law Innovations*, 45 MINN. L. REV. 1019 (1961) [hereinafter cited as Note, *Statutory and Common Law Innovations*]. For a candid view of the problem from a physician's standpoint, see W. NOLEN, A SURGEON'S WORLD 148-65 (1972).

2. *See* J. KING, JR., THE LAW OF MEDICAL MALPRACTICE 72-78 (1977); 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE ¶ 8.06 (1977 & Supp. 1979).

3. *See* notes 76-77 *infra*.

4. *See* note 74 *infra*.

pendency and helplessness[5] that patients once experienced in their dealings with the medical establishment.[6] Patients today seek access to their medical records, demand second opinions before consenting to surgery, and, in general, scrutinize their course of treatment more carefully than they did in the past.[7]

Patients are also, increasingly, turning to the courts for redress when they believe that they have suffered from negligent treatment at the hands of professionals.[8] Although it has been suggested that national health insurance or a national health service might help to diminish the resulting "malpractice crisis,"[9] these proposals have met with strong resistance.[10] It seems likely,

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5. Illness tends to make patients vulnerable, dependent, and insecure. *See* I. JANIS, PSYCHOLOGICAL STRESS: PSYCHOANALYTIC AND BEHAVIORAL STUDIES OF SURGICAL PATIENTS (1958); J. KATZ & A. CAPRON, CATASTROPHIC DISEASES: WHO DECIDES WHAT? 84-86 (1975); E. KRAUSE, POWER AND ILLNESS: THE POLITICAL SOCIOLOGY OF HEALTH AND MEDICAL CARE 90 (1977); Peck, *Emotional Responses to Having Cancer*, 114 AM. J. ROENTOLOGY, RADIUM THERAPY & NUCLEAR MED. 591, 593-96 (1972).

6. *See* E. KRAUSE, *supra* note 5, at 16.

7. *Id. See also* G. ANNAS, THE RIGHTS OF HOSPITAL PATIENTS (1975). Unfortunately, the patient-consumer movement appears to be confined to the middle and upper classes.

8. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 1.01 (Supp. 1979); 2 *id.* ¶ 20.07; Zimmerly & Smiley, *Legislators React to the Malpractice Problems*, 3 J. LEGAL MED. 30 (1975).

9. *See* H.R. 2969, 96th Cong., lst Sess., 125 CONG. REC. H1357 (daily ed. Mar. 14, 1979) ("Dellums Bill," providing for a national health service designed to bring comprehensive health services, without charge, to all residents); S. 1720, 96th Cong., 1st Sess., 125 CONG. REC. S12048 (daily ed. Sept. 6, 1979) ("Kennedy Bill," providing for a comprehensive system of national health insurance); H.R. 5400, 96th Cong., 1st Sess., 125 CONG. REC. H8506 (daily ed. Sept. 25, 1979); S. 1812, 96th Cong., 1st Sess., 125 CONG. REC. S13382 (daily ed. Sept. 25, 1979) ("Carter Bill," providing for limited health insurance and proclaiming freedom of choice in selection of health care providers for all Americans). *See generally* Weiner, *Governmental Regulation of Health Care: A Response to Some Criticisms Voiced by Proponents of a "Free Market"*, 4 AM. J. L. & MED. 15 (1978). These measures would, of course, soften the impact of malpractice only to the extent that they would provide or pay for additional medical care necessitated by the mishap. Although these bills do not appear to have been drafted with a view to reducing the incidence of malpractice, their enactment might have such an effect.

The Dellums bill, for example, would provide for lay participation in shaping health policy. The vigilance that the public might bring to decisions respecting medical care could result in a lowering of the incidence of malpractice. Nationalization of the medical profession could achieve the same effect, as physicians would be subject, presumably, to supervision by government inspectors who were not themselves doctors. Elimination of the "fee for service" concept, which is a feature of any thoroughgoing reform proposal, might reduce the incidence of unnecessary treatment, such as needless surgery. Discussion of these matters is beyond the scope of this Article, however.

10. Perhaps disagreement about what ought to be done to solve the medical malpractice crisis arises from disagreement about what the medical malpractice crisis is. Some believe the "crisis" consists of unprevented, uncorrected, or uncompensated malpractice, while others attribute its existence to rising medical fees, rising insurance

therefore, that private malpractice actions will continue to occupy the courts for some time.[11]

This Article addresses a still unresolved aspect of the "wall of silence" problem: the plight of the victim who is unaware that he or she has suffered malpractice even though members of the treatment team saw it occur.

Recent news accounts reveal truly astonishing tales of medical misconduct that went unreported and unremedied for long periods of time.[12] In one case, an anesthesiologist injected his urine into a patient during a hysterectomy.[13] The physician's bizarre behavior was reported to the Board of Medical Quality Assurance.[14] The physician had been brought before the Board on approximately ten other occasions.[15] Even so, the anesthesiologist was not immediately relieved of duty. He injected urine into at least one, and possibly two, other patients.[16] Although the doctor ultimately lost his license, no one thought to tell the victims, at least one of whom allegedly suffered physical complications from the injection.[17] This patient only learned about the incident a year-and-a-half later when she read about the physician in the newspaper. When she inquired at the hospital to find out whether she had been one of the victims, the staff at first would not tell her. On discovering that the physician had indeed injected his urine into her veins she suffered a serious mental breakdown.[18]

In another case, the parents of a three-and-a-half-year-old boy took him to a major medical center for treatment of a respiratory problem.[19] The child was placed in the adult intensive care

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rates, and soaring awards and settlements. This Article is concerned primarily with undetected and uncompensated malpractice, but will also consider the impact that measures to aid detection and prevention are likely to have on medical fees and insurance rates. *See* note 202 & accompanying text *infra*.

11. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 8.01, at 189.

12. *See, e.g.*, L.A. Times, June 1, 1980, Pt. VIII, at 1, col. 3 (describing doctor who has been sued numerous times for malpractice).

13. Boykins v. Community Hosp., No. SD-423111 (San Diego, Cal., Super. Ct., filed Sept. 26, 1978). Information concerning this case was obtained in a telephone interview with Steven Archer, attorney at law, Belli & Choulos, in Los Angeles, Cal. (Nov. 12, 1979).

14. *Id.* The California Board of Medical Quality Assurance has a duty to investigate charges of misconduct among physicians and to administer discipline where appropriate. The Board was created in 1975 by the Medical Injury Compensation Reform Act, CAL. BUS. & PROF. CODE § 2100 (West Supp. 1980).

15. Interview with Steven Archer, attorney at law, Belli & Choulos, in Los Angeles, Cal. (Nov. 12, 1979).

16. *Id.*

17. The patient allegedly developed infections, respiratory problems, and other post-surgical complication as a result of the injection. *Id.*

18. *Id.* She is presently suing all concerned. Boykins v. Community Hosp., No. SD-423111 (San Diego, Cal., Super. Ct., filed Sept. 26, 1978).

19. *See* L.A. Times, Dec. 13, 1979, Pt. X, at 15, col. 1.

unit where he was given ten times the normal dosage of a muscle relaxant designed to facilitate breathing. Later, the respirator tube slipped out of the passage leading to the boy's lungs. For several minutes, oxygen was pumped into his stomach rather than into his lungs. He suffered cardiac arrest. The physicians revived the boy, but when he opened his eyes, according to his mother, "there was nothing there;" he had suffered permanent brain damage. It was not until weeks later that the parents accidentally overheard one doctor telling another about the overdose. The physician explained that he had decided not to tell the parents because they "had enough on [their] minds already."[20] Unfortunately, this was not an isolated case.[21]

Self-policing by the medical profession is generally ineffectual.[22] Strong professional pressures keep physicians from reporting malpractice either to hospitals and state licensing boards or to victims.[23] Physicians usually prefer to register disapproval by boycotting an incompetent colleague or denying him or her the use of hospital facilities.[24] Incompetent or unstable physicians may be able to continue their juggernaut paths for months or years, however, before these unofficial sanctions make themselves felt.[25] Even then, the physician may simply transfer his or her

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20. *Id.*

21. *See* Pashley v. Pacific Elec. Ry. Co., 25 Cal. 2d 226, 153 P.2d 325 (1944) (physicians employed by defendant concealed extent of injury for over two years); Lopez v. Swyer, 115 N.J. Super. 237, 279 A.2d 116 (1971) (defendant osteopaths and radiologist concealed alleged negligence from plaintiff), *modified*, 62 N.J. 267, 300 A.2d 563 (1973); Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical-Empirical Study*, 17 UCLA L. REV. 758, 767, 768, 803 (1970). *See also* L.A. Times, Mar. 15, 1980, Pt. II, at 1, col. 1; *id.*, Mar. 16, 1980, Pt. I, at 26, col. 3 (Alleged that staff at Nevada hospital placed bets on time that various patients would die. "Angel of death" nurse alleged to have hastened death of several patients, in order to win bets, by disconnecting their oxygen supply. The betting pool was alleged to have existed for some time before an anonymous informant reported it to the authorities. The accused nurse was acquitted of all charges; the significance of this incident is that those who suspected foul play did not report it. *See* L.A. Times, May 31, 1980, Pt. I, at 12, col. 1.).

22. *See* notes 38-51 & accompanying text *infra*.

23. *See* Kelner, *supra* note 1, at 125. Professor Kelner's article presents a vivid picture of the harassment suffered by a doctor who testified for the plaintiff in a malpractice case. The doctor was "awakened repeatedly by startling phone calls in the night from . . . doctors . . . . They demanded to know why he was testifying against a doctor, what was in it for him, and how could he do such a thing? They threatened to bring the matter up at his medical society. . . . His hospital superior quizzed him on how he became 'involved' in the case." *See also* W. NOLEN, *supra* note 1, at 156, 158, 163, 166-68.

24. *See* notes 43-44 & accompanying text *infra*.

25. *See* note 45 & accompanying text *infra*. Nolen describes a surgeon who was "a real menace . . . . He . . . was drinking a lot . . . . His hands shook and mentally he was in a fog." But "[n]either the chief of surgery nor any other staff surgeon had the courage [to remove him]." W. NOLEN, *supra* note 1, at 163-64. "[D]octors just cannot be relied upon to police themselves," because of fear of hurting one an-

practice to another city or to a rural area desperate for a physician.[26]

It seems likely that the prospect of quicker, surer judicial relief for victims would help to prevent at least some malpractice.[27] The specter of stiff recoveries and increased insurance premiums may persuade some professionals to upgrade their skills, retire, or switch to areas of practice in which they are more competent. It may cause hospitals to hire physicians and grant hospital privileges more selectively than they do at present.[28] Moreover, in the absence of national health insurance or some other governmentally funded health care delivery system, only judicial relief can fully protect victims from the calamitous medical expenses, loss of function, loss of income, and pain that undisclosed malpractice can cause.[29]

Before relief can be made available, the victim or the victim's survivors must become aware that they are entitled to legal redress. Unfortunately, many do not. The following analysis considers this problem in the form of two paradigms:[30]

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other's feelings, losing referrals, "being overcritical." *Id.* at 165. "One physician, who had an M.D. from a diploma mill . . . , was apparently responsible for multiple deaths," and "had done some strange things . . . . Though numerous complaints had been lodged against him by nurses and aids . . . [he] held his post for almost six years on a continually renewed 'temporary' permit." *Id.* at 168. *But see* L.A. Times, Dec. 25, 1980, Pt. I, at 34, col. 1 (jury ruled against a neurosurgeon "who sued for $3 million, contending that his medical career was ruined because 13 anesthesiologists decided he was incompetent and refused to work with him").

26. *See* note 45 & accompanying text *infra.*

27. Causes of action in tort are created, in part, to deter immoral or pernicious behavior. *See* W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 4, at 23 (4th ed. 1971).

28. Since hospitals have been held liable for hiring or extending visiting privileges to incompetent physicians, *see, e.g.*, Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972); Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966), they might fear the additional liability which would result if a duty to disclose encouraged increased reporting of incompetence.

29. For a discussion of the inadequacy of patients' private insurance, see note 117 *infra.*

30. There is no way of knowing how often these paradigms arise; this problem does not lend itself to precise frequency counts. A review of the available literature and interviews with medical experts in varying fields of practice indicate that the paradigm cases occur all too frequently, however. The occasional widely reported cases comprise only that small portion which comes to light because of luck, unusual skepticism and perseverance on the part of a victim or family member, or the courage of a rare maverick within the medical establishment.

A review of the cases where malpractice was initially concealed but was discovered by the patient or the patient's survivors after the applicable statute of limitations had run also gives some indication of the scope of the undisclosed malpractice problem. Although physicians have attempted to raise statute of limitations defenses in such cases, many courts have rejected these defenses on grounds of "fraudulent concealment." These courts allowed the victims to bring malpractice actions even though

Paradigm #1: In the first paradigm, an unconscious patient is the victim of clear medical malpractice committed by one member of the treatment team, acting alone. A head surgeon, for example, negligently damages an organ, or leaves a piece of medical equipment inside the patient. After the operation, the patient feels pain or loss of function, but the doctor explains that this is a common outcome of the surgery.

Paradigm #2: In the second case, the patient dies as a result of the malpractice. The surviving spouse or relative is told, "We are sorry, but these things happen. We did our best."

The two paradigms share a number of elements. First, clear malpractice occurred. Second, at least one member of the treatment team observed the malpractice. Third, no one told the patient or the surviving relatives what happened. Finally, the patient was unconscious when the malpractice took place.

In both paradigms, the victims or their surviving relatives unquestionably have a primary cause of action against the treating physician for malpractice and perhaps for misrepresentation.[31] These remedies are very often unavailing, however, because the victims never realize they have been wrongfully injured—they believe that they have simply had bad luck. The thesis of this Article is that this deficiency can be remedied by judicially imposing an obligation on both the primary physician *and* on the observing members of the treatment team[32] to report the malpractice to the victim.

This Article begins by discussing the need for a duty to disclose, first showing that the medical profession does not regulate itself effectively,[33] and then illustrating the importance of a duty of disclosure in light of the inherent inequality present in the doctor-patient relationship.[34] It then considers recent developments in tort theory which suggest that a duty to disclose malpractice would constitute a small, but logical next step in the continuing development of tort doctrine.[35] Next, it outlines the prima facie case for, and defenses to, an action for breach of the proposed

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the statutes had run. Such cases are legion. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 13.11 nn.67-70.

31. *See* Lopez v. Swyer, 115 N.J. Super. 237, 279 A.2d 116 (1971) (holding that patient had cause of action for misrepresentation as a result of physician's statement that severe burns were normal result of radiation treatment), *modified*, 62 N.J. 267, 300 A.2d 563 (1973).

32. For a discussion of the need to extend the duty to observing treatment team members who have not committed malpractice, see text accompanying notes 102-25 *infra*.

33. *See* text accompanying notes 38-54 *infra*.

34. *See* text accompanying notes 55-61 *infra*.

35. *See* text accompanying notes 68-141 *infra*.

duty to disclose.[36] Finally, the Article considers objections that might be made to a duty of disclosure, and offers answers to those objections.[37]

I. THE NEED FOR A DUTY TO DISCLOSE

A duty to disclose malpractice to the patient is needed for several reasons. First, the medical profession's self-policing is inadequate and rarely, if ever, provides relief to the victims of malpractice. Second, the doctor-patient relationship is inherently unequal because doctors and other medical personnel have greater knowledge concerning the patient's illness and its treatment than do most patients. Third, additional physical harm may occur if malpractice is not discovered promptly and its effects remedied. Fourth, delay in discovering malpractice decreases the likelihood that a malpractice suit will be successful. Finally, without a duty of disclosure, many malpractice victims will remain uncompensated.

A. *Self-Regulation: Professional Pressures to Prevent Disclosure*

Most commentators agree that the medical profession does not regulate itself effectively.[38] Licensing boards,[39] medical socie-

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36. See text accompanying notes 142-54 *infra* for a discussion of the prima facie case; text accompanying notes 155-65 *infra* for a discussion of possible defenses to the prima facie case.

37. *See* text accompanying notes 166-209 *infra*.

38. *See, e.g.*, E. FREIDSON, THE PROFESSION OF MEDICINE 137-57 (1970); E. KRAUSE, *supra* note 5, at 279-85. *See also* W. NOLEN, *supra* note 1, at 148-68 (malpractice rarely checked); *id.* at 289-93 (unnecessary surgery—referred to as "acute remunerative appendectomies"—tolerated). *Cf.* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 2.04 (describing various regulatory mechanisms at work within the profession, with differing degrees of effectiveness).

According to the ethical principles of the medical profession, a physician must report any accident, injury, or bad result stemming from his or her treatment. *See* AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS § 4 (1957) ("[Physicians] should expose, without hesitation, illegal or unethical conduct of fellow members of the profession."), *quoted in* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 2.04, at 19 n.8. *See also* sources discussed in Hagman, *supra* note 21, at 804 n.174. A new code of medical ethics adopted in 1980 by the AMA, telephone interview with Denise Thiercof, Los Angeles County Medical Association Ethics Dep't, in Los Angeles, (Nov. 17, 1980) does not weaken this requirement. *See* AMERICAN MEDICAL ASSOCIATION, DRAFT: PRINCIPLES OF MEDICAL ETHICS (1979) (rule II: "A physician shall uphold the honor of the profession by dealing honestly with patients and colleagues, and striving to expose those physicians deficient in character, competence, or who engage in deception."), *discussed in* Veatch, *Professional Ethics: New Principles for Physicians*, HASTINGS CENTER REP., June 1980, at 16, 17; TIME, Aug. 4, 1980, at 53, col. 1. Most doctors interpret these requirements as compelling them to report the mishap to their superiors or to the hospital's pathology committee, rather than to the patient. Telephone interview with Andrew Dolan, Associate Professor of Health Services, University of Washington (Jan. 11, 1980); 1952 CONG. Q. EDITORIAL REP.: SUPPRESSION OF MEDICAL ABUSES 775.

39. Although licensing boards are technically agencies of the state, they tend to

ties, and hospital review committees responsible for most of the regulation[40] generally focus their efforts on training and licensing procedures. Unfortunately, this emphasis on training and certification serves more to regulate the numbers and quality of entering physicians than to provide a check on the competence of those already in practice.[41] Doctors are rarely disciplined formally by their peers even when their malpractice is blatant and continuous.[42] Professional sanctions, when imposed, usually take the form of refusals to enter into referral or collaborative relationships with the offending doctor[43] or, occasionally, denials of access to hospital facilities.[44] These sanctions do not control the doctor's behavior; they merely push him or her "outside the boundaries of observability and influence."[45] Moreover, they provide no relief

be dominated by doctors. See E. FREIDSON, *supra* note 38, at 25-33; E. KRAUSE, *supra* note 5, at 203, 279-85.

40. E. FREIDSON, *supra* note 38, at 138-39; 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 2.04.

41. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 6.02 ("[T]he profession's advice to its members on minimization of legal liability often seems to proceed from the premise that the primary objective should be . . . to . . . forestall lawsuits, and the secondary objective [should be] . . . to reduce bad medical practice."); E. RAYACK, PROFESSIONAL POWER AND AMERICAN MEDICINE 5-6, 100 (1967) (AMA limits number of physicians, thereby reducing competition and keeping fees high).

Moreover, at least one commentator has questioned the training and licensing procedures used by some boards. *See* W. NOLEN, *supra* note 1, at 167-68 (licensing board lowered standards to pass a doctor "with influential friends").

42. Only 770 disciplinary actions were brought against physicians nationwide in 1978. Only 126 physicians were disciplined in California in that year. L.A. Times, Nov. 27, 1979, Pt. II, at 1, col. 4. *See also* E. KRAUSE, *supra* note 5, at 284; 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 2.03; Phillips & Noie, *Identifying Unfit-Physicians—The Hospital's Responsibility,* HOSP. MED. STAFF, Apr. 1976, at 1.

See also 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 2.04 (many state statutes fail to provide for disciplinary proceedings based on malpractice). In one instance, an uncertified cosmetic surgeon continued his illegal practice for 12 years before the Board of Medical Quality Assurance filed charges. Numerous police complaints had been brought to the Board's attention during that time, but only a few physicians had filed complaints. By the time the Board commenced action, at least $2,329,973 in malpractice settlements, jury verdicts and default judgments had been awarded to the surgeon's ex-patients. *See* L.A. Times, June 1, 1980, Pt. VIII, at 1, col. 2.

43. *See* E. FREIDSON, PROFESSIONAL DOMINANCE 94 (1970).

44. *Id.* at 94-96; 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 2.04. *See also* W. NOLEN, *supra* note 1 at 166, 168, 185-86; Note, *Expulsion and Exclusion From Hospital Practice and Organized Medical Societies,* 15 RUTGERS L. REV. 327 (1961).

45. E. FREIDSON, *supra* note 43, at 94. Proponents of self-regulation by the medical profession might argue that a physician who is ostracized by colleagues and denied referrals and hospital privileges will eventually leave practice. An ostracized physician does not always leave practice, however. Instead, such a physician may transfer his or her practice to a different region or open a clinic or a sole practice.

See also W. NOLEN, *supra* note 1, at 144 (doctor knew that colleague had failed to diagnose chest pain as a coronary, but deliberately withheld this information from the patient); *id.* at 145 (First doctor made an incorrect diagnosis, necessitating an emergency operation to save a child's life. Author told parent that the child devel-

for patients injured by the doctor's incompetence.

At the same time, the medical profession insulates itself from outside review. This insulation "is a powerful social fact which allows behavior that others . . . would not condone if they knew of its existence."[46] Formal and informal mechanisms "protect the physician from observation . . . through both their structure and their deliberate nonfunctioning as self-regulatory agencies."[47]

One aspect of this resistance to outside review is the united front physicians often present when a colleague is sued for malpractice. Despite recent advances,[48] this "conspiracy of silence" continues to make it difficult for plaintiffs to find physicians willing to testify, even in cases of egregious misconduct.[49] Doctors who do testify risk being boycotted by other physicians,[50] or losing their malpractice insurance.[51] The patient cannot, therefore, depend on peer pressure to motivate physicians to inform him or her that malpractice has been committed.

A judicially imposed duty of disclosure might prove helpful to such patients because doctors and nurses who wish to report

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oped the condition while in the hospital. "What I'd told them was the truth, sort of. . . . [T]here was no sense in suggesting that Joe [the other doctor] has missed the diagnosis. It wouldn't do the family any good and would only hurt Joe. I knew he'd protect me if the roles were reversed . . . .").

46. E. KRAUSE, *supra* note 5, at 40.

47. *Id. See also* W. NOLEN, *supra* note 1, at 163-68.

48. *See* notes 1-4 & accompanying text *supra*; notes 84-108 & accompanying text *infra*.

49. [F]or decades, almost no physician would testify that a colleague had blundered. In the privacy of his office, a doctor might tell you that a certain brother of the scalpel was a blunderer who, in his gross incompetence, had maimed his patient. However, on the witness stand, he would prejure [sic] himself in firm tones, declaring the defendant to be a skilled surgeon exercising his best medical judgment.

Appleman, *The* Darling *Case—A "Real" Tiger*, 1975 INS. L.J. 714, 714-15. *See* sources cited in note 1 *supra*; L'Orange v. Medical Protective Co., 394 F.2d 57 (6th Cir. 1968) (insurance company cancelled dentist's policy in order to coerce him not to testify in malpractice action). *See also* Christie v. Callahan, 75 App. D.C. 133, 138, 124 F.2d 825, 828 (D.C. Cir. 1941) ("Physicians . . . are loath to testify [against] a fellow craftsman . . . ."); Salgo v. Leland Stanford Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 568, 317 P.2d 170, 175 (1957) ("No matter how lacking in skill or how negligent the medical man might be, it was almost impossible to get other medical men to testify adversely to him."); 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶¶ 1.05, 7.08, 14.01-.03; W. NOLEN, *supra* note 1, at 148, 158-59, 207 (doctor lied to protect reputation of prestigious medical clinic).

50. *See* Kelner, *supra* note 1, at 123 ("The doctor willing to testify is inviting social and professional ostracism in his county medical society—and worse."); *id.* at 125 ("Nightriders" and hospital superiors pressured doctor not to testify in malpractice case.).

51. *See, e.g.*, Klabunde v. Stanley, 16 Mich. App. 490, 168 N.W.2d 450 (1969) (plaintiff did not want to name his expert witness because the physician had lost his malpractice insurance following an earlier malpractice case in which he had testified for plaintiff), *rev'd*, 384 Mich. 276, 181 N.W.2d 918 (1970).

malpractice could do so without the degree of risk that presently exists. As matters now stand, doctors can justify reporting malpractice to the patient only by declaring that their personal sense of morality or concern for the patient demands it. Some physicians feel that these reasons should be outweighed by a doctor's loyalty to his or her colleagues.[52] If the duty to report becomes a legal obligation, physicians could explain to colleagues and superiors that they were merely complying with the law in disclosing malpractice. Those who came forward could be protected from vindictive physicians or administrators by doctrines forbidding retaliatory conduct.[53]

A duty to disclose would also place additional pressure on government agencies and medical societies to take effective action to reduce the incidence of malpractice. Spurred by the increased number of cases likely to be brought and their attendant publicity, existing regulatory mechanisms would gain new life. Thus, the proposed duty would both aid victims of malpractice and strengthen the mechanisms designed to prevent malpractice.[54]

B. *Unequal Access to Information*

Patients need medical information in order to evaluate their illnesses and scrutinize the treatment they receive.[55] It is often dif-

52. *See, e.g.*, W. NOLEN, *supra* note 1, at 148, 160, 165-66 ("Hardly ever does any doctor on the staff approach any other doctor and question his practice methods. It just isn't done.").

53. The need for protection against retaliatory action is patent. *See* note 50 *supra*. Rules against retaliation exist in other areas of the law. *See, e.g.*, Barnes v. Costle, 561 F.2d 983 (D.C. Cir. 1977) (labor law); Edwards v. Habib, 397 F.2d 687 (D.C. Cir. 1968) (landlord-tenant relations), *cert. denied*, 393 U.S. 1016 (1969); Schweiger v. Superior Court, 3 Cal. 3d 507, 476 P.2d 97, 90 Cal. Rptr. 729 (1970) (landlord-tenant relations); CAL. HEALTH & SAFETY CODE § 1432(b) (West 1979) (patients' rights regarding evictions from health care facilities). These rules against retaliation only come into play, however, when the person seeking protection acted to enforce a legally recognized right; they do not apply to cases in which the person seeking protection acted solely from moral compulsion. *Edwards v. Habib*, for instance, granted protection against retaliatory eviction to tenants who availed themselves of legislative remedies.

54. The proposed duty to disclose might be extended to apply directly to regulatory agencies, in addition to being used to pressure such agencies indirectly. Imposition of liability would, of course, be rare. To prevail, the plaintiff would have to prove the elements of the prima facie case, *see* notes 142-54 & accompanying text *infra*, *and* show that the agency was not protected by sovereign immunity.

55. Aside from their need for information to evaluate treatment, patients may simply want to know what has happened to them. The Golden Rule supports a duty to disclose; if we were malpractice victims we would presumably wish to be notified rather than kept in ignorance of the damage that had been done to our bodies. *See* J. RAWLS, A THEORY OF JUSTICE 48-49 (1971) (persons should choose moral principles as though prevented by a veil of ignorance from knowing what position they would occupy in a society governed by these principles).

ficult for them to obtain this information.[56] Practices and policies are "deliberately chosen by health-care workers which confuse and misinform patients, for the convenience of the setting and the comfort of the workers."[57] Although "these [are] . . . under attack by the 'patient rights' movement, . . . the process continues because it is so deeply embedded in the normal scheme of things."[58] Health care professionals assume that "expertise [should] be possessed by one group, and [that] the patient is not . . . better off with a technical knowledge of his problem."[59] Answering questions takes time away from other duties. Also, an informed patient may challenge his or her treatment, demand information that embarrasses the doctor or staff, or sue. Thus, to health care workers, it may appear "far easier not to tell the patient anything unless [required] to do so."[60]

The surest way to be certain that patients are adequately informed may be to require disclosure of malpractice. Doctors and nurses are certainly in a better position than patients to know whether it has occurred; the legal system generally places the burden of disclosure on the party most likely to have access to needed information.[61]

C. *Risk of Further Harm to Patients*

Another reason for a duty to disclose malpractice is the risk of further physical harm if the victim is not notified. In some cases sponges, clamps, or other items of surgical equipment have been left in the patient, yet nothing has been said to him or her.[62] In other cases, surgical procedures have been carried out improp-

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56. *See* notes 57-60 & accompanying text *infra*. *See also* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶¶ 5.03-.04, 6.02 n.1, 7.09 (fear of malpractice suits may cause alteration of hospital records and destruction of committee reports).

57. E. KRAUSE, *supra* note 5, at 116. *See* R. BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS 102 (1979). *But see* Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 140-41 (1977).

58. E. KRAUSE, *supra* note 5, at 116.

59. *Id. See also* R. BURT, *supra* note 57, at 124-27; 2 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 22.01; W. NOLEN, *supra* note 1, at 145.

60. E. KRAUSE, *supra* note 5, at 116.

61. *See* text accompanying notes 84-91 *infra* (obligations arising from fiduciary relationship); Neel v. Magana, 6 Cal. 3d 176, 491 P.2d 421, 98 Cal. Rptr. 837 (1971). *See also* W. PROSSER, *supra* note 27, § 106, at 697.

62. *See, e.g.*, Landgraff v. Wagner, 26 Ariz. App. 49, 546 P.2d 26 (clamp left in patient), *appeal dismissed*, 429 U.S. 806 (1976); Young v. Caspers, 311 Minn. 391, 249 N.W.2d 713 (1977) (broken tip of scalpel left in patient); Hestbeck v. Hennepin County, 297 Minn. 419, 212 N.W.2d 361 (1973) (sponge left in patient). A complaint which was recently filed in Santa Monica Superior Court against a primary physician and a hospital alleges that the physican left a sponge in the patient. It further alleges that, although the sponge was seen by the radiologist and others at the hospital, no one told the patient or his wife. The patient died during a further series of operations

erly, again without the patient's being notified.[63] As a result of nondisclosure, the victim may suffer complications, including continued illness or even death. In these cases, there is an obvious and strong public interest in requiring disclosure so that the patient may have the object removed or the condition treated.

D. *Delayed Recovery and Statutes of Limitations*

In a number of states, the statute of limitations does not start to run until the patient actually discovers the injury or receives effective notice of it.[64] Other states either lack a comparable rule or set a maximum period after which actions cannot be brought even if discovery is delayed through no fault on the part of the patient.[65] In either case, the earlier the victim can file, the better—the longer the delay, the greater the likelihood that evidence will be destroyed, witnesses will move or die, files will be misplaced or lost, and memories will fade. In addition, when filing is delayed, the victim potentially faces medical expenses and loss of income during the entire period of the delay.[66] This may prove a particularly heavy burden for the members of a family which loses its

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allegedly necessitated by the presence of the sponge. Interview with Robert Gans, M.D., attorney at law, in Westwood, Cal. (Oct. 10, 1979).

63. *See, e.g.*, Stills v. Gratton, 55 Cal. App. 3d 698, 127 Cal. Rptr. 652 (1976) (gynecologist performed unsuccessful abortion but did not inform the patient, even though he received a report from the hospital's pathologist indicating that the fetus was still in place; the patient did not discover the error until it was too late to have another abortion); Wambold v. Brock, 236 Iowa 758, 19 N.W.2d 582 (1945) (dentist fractured patient's jaw while extracting a tooth, but did not tell the patient about the injury); Simcuski v. Saeli, 44 N.Y.2d 442, 377 N.E.2d 713, 406 N.Y.S.2d 259 (1978) (surgeon negligently injured a spinal accessory nerve in the patient's neck but concealed the injury from the patient, who did not discover the error until it was too late for corrective surgery).

64. *See, e.g.*, Lopez v. Swyer, 115 N.J. Super. 237, 279 A.2d 116 (1971), *modified*, 62 N.J. 267, 300 A.2d 563 (1973); Flanagan v. Mount Eden Gen. Hosp., 24 N.Y.2d 427, 248 N.E.2d 871, 301 N.Y.S.2d 23 (1969). *See also* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 13.07 (listing states that have adopted this "discovery rule").

65. *See* statutes cited in 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 13.07 nn.44, 45 (Supp. 1979). In the period 1975 to 1979, during the height of the "malpractice crisis", a number of states reduced the maximum period set by their statutes of limitations in order to decrease the number of malpractice suits that could be brought. *See, e.g.*, CAL. CIV. PROC. CODE § 340.5 (West Supp. 1980) (reducing the statutory period for bringing malpractice actions from four to three years); N.Y. CIV. PRAC. LAW § 214-a (McKinney Supp. 1979) (reducing the statutory period from three to two-and-a-half years). *See also* 2 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 20.07 (Supp. 1979).

66. It is especially important that victims go to court early—before their damages increase with time—where the amount which can be recovered in a malpractice action has been limited by statute. In California, for example, the legislature reacted to the malpractice crisis by limiting recovery for noneconomic losses, including pain and suffering and physical impairment, to $250,000. CAL. CIV. CODE § 3333.2(b) (West Supp. 1980). The legislature also restricted subrogation in malpractice cases, CAL. CIV. CODE § 3333.1 (West Supp. 1980), and limited contingency fees for attorneys

principal wage-earner. They may, for example, be required to sell their home and forfeit work or educational opportunities. A recovery in ten or twenty years comes too late to remedy these losses fully. If there is a separate duty to disclose and that duty is not met, at least victims will be able to recover more compensation than they would otherwise have been able to obtain.[67] In addition, the existence of a legal duty may make it more likely that some member of the treatment team will come forward to report the original malpractice, making recourse to the new cause of action unnecessary.

II. RELATED DEVELOPMENTS IN TORT THEORY

A judicially recognized cause of action for nondisclosure of malpractice would constitute not a major departure from, but rather a small and logical next step in a continuous line of tort doctrine. Courts have recognized that patients are at a disadvantage when they deal with the medical profession,[68] that patients are almost totally dependent on physicians for medical information,[69] and that there are few ways in which a layperson can independently ascertain what treatment his or her illness requires.[70] Courts have addressed this imbalance within the doctor-patient relationship in two ways. They have developed doctrines that make it less difficult for a victim of malpractice to sue successfully,[71] and they have placed affirmative duties on physicians to provide patients with information they need to make informed decisions regarding treatment.[72]

A. *Keeping the Plaintiff in Court Despite the "Conspiracy of Silence"*

Largely in response to the "conspiracy of silence,"[73] the

representing clients in such actions, CAL. BUS. & PROF. CODE § 6146 (West Supp. 1980).

67. The victim should be able to recover for nondisclosure from members of the treatment team even if he or she is unable to recover for the original malpractice because of the death, retirement, or absence from the jurisdiction of the malpracticing physician.

68. *E.g.*, Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 242, 502 P.2d 1, 9, 104 Cal. Rptr. 505, 513 (1972).

69. *See, e.g.*, cases cited in note 68 *supra*; Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960). *See also* notes 55-61 & accompanying text *supra* (patients' access to information restricted).

70. *See* cases cited in notes 68, 69 *supra*.

71. *See* notes 73-79 & accompanying text *infra*.

72. *See* notes 96-101 & accompanying text *infra*.

73. *See* note 1 *supra*. Substantive considerations, such as burden-shifting in order to advantage plaintiffs at the expense of stubbornly silent defendants, may have also played a part in the development of these doctrines.

courts have allowed plaintiffs to use res ipsa loquitur,[74] established national standards for expert witnesses,[75] permitted plaintiffs to substitute medical books for expert testimony,[76] and allowed plaintiffs to dispense with expert testimony altogether under certain circumstances.[77] Unfortunately, these doctrines assist only the victim who knows about the malpractice and is trying to prove it in court. The cases that come nearest to recognizing the problem of nondisclosure are those in which the statute of limitations is held not to start running until the victim discovers or should discover his or her injury.[78] The rationale for this "discov-

74. To establish that res ipsa loquitur ("the thing speaks for itself") can be applied to a case, the plaintiff must show: (1) that the injury or the event that caused the injury is of a kind which ordinarily does not occur in the absence of someone's negligence; (2) that the injury or event was caused by an agency or instrumentality within the exclusive control of the defendant; and, (3) that the injury or event was not due to any voluntary action or contribution by the plaintiff. W. PROSSER, *supra* note 27, §39, at 214. Some courts have suggested that the plaintiff must also show that the true explanation of the event causing the injury is more readily accessible to the defendant than to the plaintiff. *Id.* In some jurisdictions, proof of these elements creates a rebuttable presumption that the defendant's negligence caused the injury. If the defendant fails to rebut the presumption, the plaintiff prevails. *Id.* § 40, at 230-31. In most jurisdictions, proof of the requisite elements will entitle the jury to infer negligence, but creates no presumption of it. *Id.* at 228-30. Where a special relationship, such as that between doctor and patient, exists between plaintiff and defendant, a court is more likely to apply the rebuttable presumption version of the doctrine, however. *Id.* at 231. *See also* Clark v. Gibbons, 66 Cal. 2d 399, 426 P.2d 525, 58 Cal. Rptr. 125 (1967); Ybarra v. Spangard, 25 Cal. 2d 486, 154 P.2d 687 (1944); 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 14.04-.05.

75. At one time, expert witnesses were required to have practiced in the geographic area where the malpractice occurred in order to testify about the medical standard of care in that area. While this rule prevailed, a plaintiff's chances of finding a doctor willing to testify were miniscule. J. KING, JR., *supra* note 2, at 72-78. Most jurisdictions have discarded this rule, however, on the ground that recent improvements in communications technology have created a national medical standard of care; plaintiffs can now introduce medical experts from other parts of the country. *See, e.g.*, Christopher v. United States, 237 F. Supp. 787 (E.D. Pa. 1965); Murphy v. Little, 112 Ga. App. 517, 145 S.E.2d 760 (1965); Chandler v. Neosho Memorial Hosp., 223 Kan. 1, 574 P.2d 136 (1977); Tallbull v. Whitney, 172 Mont. 326, 564 P.2d 162 (1977); Hirschberg v. New York, 91 Misc. 2d 590, 398 N.Y.S.2d 470 (1977). Further, many jurisdictions have relaxed the requirement that the expert be a specialist in the type of medicine involved in the suit. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 11.30 n.23.

76. Some states permit plaintiffs to show, with the aid of medical books, that the doctor's conduct fell below the customary standard in the medical profession. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 8.01 n.10; Note, *Statutory and Common Law Innovations*, *supra* note 1, at 1019.

77. The plaintiff can dispense with expert testimony when the type of injury is such that expert testimony is unnecessary to show negligence. *See, e.g.*, Higdon v. Carlebach, 348 Mich. 363, 83 N.W.2d 296 (1957) (dentist's drill cut patient's tongue); Hestbeck v. Hennepin County, 297 Minn. 419, 212 N.W.2d 361 (1973) (foreign object left in body); Griffin v. Norman, 192 N.Y.S. 322 (Sup. Ct. 1922) (dentist removed wrong tooth).

78. A number of states have adopted this "discovery" rule. *See, e.g.*, Lipsey v. Michael Reese Hosp., 46 Ill. 2d 32, 262 N.E.2d 450 (1970); Tomlinson v. Siehl, 459

ery rule" is that patients often rely on their physicians and have no independent means of discovering negligence in treatment. Victims now often discover negligence by accident.[79] The proposed duty would enable them to learn about malpractice without having to rely on chance.

B. *Affirmative Duties and Medical Malpractice*

Traditionally, the common law did not impose affirmative duties in the absence of a special relationship between the parties.[80] Thus, neither bystanders nor physicians have ever been required to render aid in an emergency.[81] The common law attempted, instead, to "encourage" rescue by means of "Good Samaritan" statutes:[82] in return for rendering aid at the scene of an emergency, doctors were protected from liability for negligence and sometimes allowed to collect fees from the victim.[83]

Recent tort cases have altered the common law, often by expanding the "special relationship" concept.[84] For example, where one party is dependent on another for information or knowledge

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S.W.2d 166 (Ky. 1970); Lopez v. Swyer, 115 N.J. Super. 237, 279 A.2d 116 (1971), *modified*, 62 N.J. 267, 300 A.2d 563 (1973); Flanagan v. Mount Eden Gen. Hosp., 24 N.Y.2d 427, 248 N.E.2d 871, 301 N.Y.S.2d 23 (1969); 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 13.07 nn.44-49 & Supp. ¶ 13.07, at 224-25. For example, in *Lopez v. Swyer*, the plaintiff was seriously burned during radiation treatments for cancer but did not discover the radiologist's negligence until after the statute of limitations had run. The Appellate Division held that the statute should be tolled until the patient "discovered or should have discovered" that the treatment was negligently administered. The New Jersey Supreme Court modified the decision, holding that the question of the "discovery" rule and the statute of limitations is to be decided by the trial judge, not the jury.

79. *See, e.g.*, Lopez v. Swyer, 115 N.J. Super. 237, 279 A.2d 116 (1971) (victim overheard other radiologists discussing the malpractice), *modified*, 62 N.J. 267, 300 A.2d 563 (1973).

80. The basis for this rule seems to lie in notions of liberty and laissez faire economics: it is less onerous to require persons to refrain from injuring others than to require them to give positive aid. For an example of a situation where a court found a special relationship which compelled the creation of an affirmative obligation, see Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 435, 551 P.2d 334, 343, 131 Cal. Rptr. 14, 23 (1976). *See also* W. PROSSER, *supra* note 27, § 56, at 338-43; Franklin, *Vermont Requires Rescue: A Comment*, 25 STAN. L. REV. 51, 51-53 (1972); Note, *Stalking the Good Samaritan: Communists, Capitalists and the Duty to Rescue*, 1976 UTAH L. REV. 529, 529-32 [hereinafter cited as Note, *Stalking the Good Samaritan*].

81. *See, e.g.*, 2 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶¶ 21.01-.34.

82. *See id.*; W. PROSSER, *supra* note 27, § 56, at 344.

83. *See* note 82 *supra*. *But see* 2 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 21.40 nn.75-95 (some states protect "Samaritan" doctors from liability only if they render aid gratuitously).

84. One case even extended the duty to rescue far beyond the special relationship requirement. In Farwell v. Keeton, 396 Mich. 281, 240 N.W.2d 217 (1976), the court held that the defendant had a duty to obtain medical aid for his injured friend following an accident. The court based its conclusion on a finding that the defendant and the friend were on a "joint venture" when they went out together for an "evening of

that only the first party possesses, the courts have imposed "fiduciary" obligations on the party in the superior position.[85] Physicians, like most professionals,[86] are considered fiduciaries vis-à-vis their patients.[87] Fiduciaries have an affirmative duty to disclose all information relevant to the protected party's interests, including information regarding any loss or injury caused by the fiduciary.[88] Failure to disclose constitutes misrepresentation and is compensable in an action for tort.[89] Despite their characterization of physicians as fiduciaries for other purposes, the courts have generally not interpreted the principle of affirmative disclosure to require disclosure of the physician's own malpractice.[90] The creation of a duty to disclose would put the medical relationship on the same legal footing as other fiduciary relationships.[91]

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recreation." *Id.* at 291-92, 240 N.W.2d at 222. No other court seems to have gone this far in establishing a duty to rescue.

There is, however, a line of commercial cases which could conceivably be extended to impose a duty of disclosure on members of the treatment team who observe, but do not commit, malpractice. These cases hold that persons acting in concert with fiduciaries are required to meet "fiduciary" standards of fairness. *See, e.g.*, Jackson v. Smith, 254 U.S. 586, 588-89 (1921); Miller v. Steinbach, 268 F. Supp. 255, 281 (S.D.N.Y. 1967). Thus, in those jurisdictions that require the malpracticing physician to disclose malpractice, observing members of the treatment team might also be required to disclose malpractice.

85. *See, e.g.*, Hobart v. Hobart Estate Co., 26 Cal. 2d 412, 159 P.2d 958 (1945) (stockbroker); Knapp v. Knapp, 15 Cal. 2d 237, 100 P.2d 759 (1940) (trustee); Rutherford v. Rideout Bank, 11 Cal. 2d 479, 80 P.2d 978 (1938) (banker). For a general discussion of fiduciary obligations, see Bayer v. Beran, 49 N.Y.S.2d 2 (Sup. Ct., Spec. Term 1944) (fiduciaries must subordinate their personal interests to the interests of their clients).

86. Lawyers, too, are considered fiduciaries. *See, e.g.*, Neel v. Magana, 6 Cal. 3d 176, 491 P.2d 421, 98 Cal. Rptr. 837 (1971); Schaefer v. Berinstein, 140 Cal. App. 2d 278, 295 P.2d 113 (1956).

87. *See, e.g.*, Pashley v. Pacific Elec. Ry., 25 Cal. 2d 226, 235, 153 P.2d 325, 329-30 (1944); Wohlgemuth v. Meyer, 139 Cal. App. 2d 326, 331, 293 P.2d 816, 820 (1956); Lopez v. Swyer, 115 N.J. Super. 237, 251, 279 A.2d 116, 124 (1971), *modified*, 62 N.J. 267, 300 A.2d 563 (1973).

88. *See, e.g.*, Neel v. Magana, 6 Cal. 3d 176, 491 P.2d 421, 98 Cal. Rptr. 837 (1971) (statute of limitations tolled because of attorney's failure to disclose legal malpractice); Hobart v. Hobart Estate Co., 26 Cal. 2d 412, 159 P.2d 958 (1945) (stockbroker concealed his wrong-doing); Knapp v. Knapp, 15 Cal. 2d 237, 100 P.2d 759 (1940) (statute of limitations tolled because trustee had concealed his wrongdoing from client); Rutherford v. Rideout Bank, 11 Cal. 2d 479, 80 P.2d 978 (1938) (banker concealed his fraud); Schaefer v. Berinstein, 140 Cal. App. 2d 278, 295 P.2d 113 (1956) (attorney concealed his fraud).

89. *See* W. PROSSER, *supra* note 27, § 106, at 697 (rule applies to banker and client, principal and agent, executor and beneficiary, lawyer and client).

90. *See, e.g.*, Millett v. Dumais, 365 A.2d 1038 (Me. 1976) (doctor has no obligation to give patient "legal advice" by disclosing malpractice). *But see* Lopez v. Swyer, 115 N.J. Super. 237, 279 A.2d 116 (1971) (where radiologist concealed malpractice by telling patient that x-ray burns were a normal part of treatment, statute of limitations tolled until patient discovered malpractice), *modified*, 62 N.J. 267, 300 A.2d 563 (1973).

91. No case has articulated reasons for the current disparate treatment. Perhaps

A few courts have recognized an obligation on the part of the primary physician to disclose the injury to the patient.[92] Failure to inform is viewed either as a breach of the doctor's duty of due care and thus as part of the original malpractice,[93] or as misrepresentation by silence.[94]

There are two difficulties with assimilating the duty of disclo-

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courts have treated physicians differently because the duties performed by physicians are different in nature from those performed by other fiduciaries. Other fiduciaries invest money, draft legal documents, or manage the business affairs of the client. Therefore, a disclosure of a financial loss, unwise investment, or other failure of management can quite naturally be seen as an aspect of the duty which the fiduciary owes the client.

With respect to disclosure of medical malpractice, the case is less clear. Disclosure of a slip of the knife, an incorrect injection, or the improper setting of a fracture may be seen as a legal duty, not a *medical* one. Thus, courts may have refrained from making disclosure an aspect of the malpracticing physician's fiduciary obligation because they felt that disclosure was a nonmedical matter. *See* Millett v. Dumais, 365 A.2d 1038, 1041 (Me. 1976) (declining to require disclosure of malpractice because such disclosure would require the physician to make a "legal" judgment).

92. *See, e.g.*, Stafford v. Shultz, 42 Cal. 2d 767, 270 P.2d 1 (1954); Pashley v. Pacific Elec. Ry., 25 Cal. 2d 226, 153 P.2d 325 (1944); Wohlgemuth v. Meyer, 139 Cal. App. 2d 326, 293 P.2d 816 (1956); Bowman v. McPheeters, 77 Cal. App. 2d 795, 176 P.2d 745 (1947); Lopez v. Swyer, 115 N.J. Super. 237, 279 A.2d 116 (1971), *modified*, 62 N.J. 267, 300 A.2d 563 (1973). *See also* Hagman, *supra* note 21, at 767, 803.

It should be noted that, since most instances of medical malpractice do not present grounds for criminal prosecution, 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 15.01, the fifth amendment does not provide physicians with an excuse for nondisclosure.

93. *See, e.g.*, Millett v. Dumais, 365 A.2d 1038, 1041 (Me. 1976); Simcuski v. Saeli, 44 N.Y.2d 442, 452, 377 N.E.2d 713, 718, 406 N.Y.S.2d 259, 264-65 (1978).

94. *See, e.g.*, Morrison v. Acton, 68 Ariz. 27, 34-35, 198 P.2d 590, 595 (1948) (failure to disclose was constructive fraud); Stafford v. Shultz, 42 Cal. 2d 767, 771, 270 P.2d 1, 7 (1954) (doctor had responsibility as fiduciary to make full disclosure to patient); Sperandio v. Clymer, 563 S.W.2d 88 (Mo. 1978) (surgeon guilty of conspiracy to keep patient unaware of malpractice of other doctors); Lopez v. Swyer, 115 N.J. Super. 237, 279 A.2d 116 (1971), *modified*, 62 N.J. 267, 300 A.2d 563 (1973) (failure to disclose constituted constructive misrepresentation). *See also* sources cited in 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 4.15.

While misrepresentation is, of course, a tort of intent, it is unclear whether nondisclosure would be characterized by most courts as an intentional or as a negligent tort. Characterization of nondisclosure as an intentional tort would make punitive damages available to plaintiffs, 2 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 18.12 (punitive damages available for intentional malpractice), and prevent physicians from relying on malpractice insurance to cover plaintiffs' recoveries, *id.* ¶¶ 20.02, 20.03 n.27 (most malpractice policies do not cover intentional torts). Thus, if nondisclosure were labeled an intentional tort, physicians would be forced to pay large judgments out of their personal funds. It is difficult to know whether most courts would view this as a positive result which advanced deterrence and compensation interests, or as an unduly harsh punishment of physicians.

An action for nondisclosure might even sound in contract; it could be argued that a doctor who assumes responsibility for the care of a patient enters an implied contract to tell the patient of any injuries caused by the doctor's negligence. Historically, malpractice actions were commonly brought under theories of express or implied contract. *See generally* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 8.03, at 197, 199.

sure to the doctor's duty of due care. The first is that doctor's *care* ordinarily connotes the diagnosis and treatment of disorders. A duty to inform patients of untoward consequences of treatment seems to go somewhat beyond a duty to treat them with due care, especially when the consequences of nondisclosure are only economic, not physical. The second difficulty is that the duty of due care, like most tort duties, is a negative one—to avoid harming the patient. The proposed duty to disclose, in contrast, would be an affirmative duty.

The difficulty with relying on a misrepresentation theory, *simpliciter*, is that misrepresentation generally must be active, rather than passive, in the absence of special circumstances or relationships. Neither conceptualization seems expandable to reach observing members of the treatment team who fail to disclose the primary physician's malpractice.[95] Finally, an independent duty would give parties notice of their rights and obligations and avoid contorting existing theories to reach a result that can be reached more naturally by recognizing a separate duty.

No court has, to our knowledge, imposed a duty of disclosure on members of the treatment team who do not commit malpractice, but observe it and keep silent. These persons already have a duty to treat patients with due care; strong policy reasons support extending this duty to require disclosure of malpractice to the patient. Moreover, existing tort doctrines support the expansion of this duty.

1. Duty to Obtain Informed Consent

The rationale for a duty to disclose on the part of the primary physician is similar to that which underlies the doctrine of informed consent.[96] The primary purpose of requiring the patient's

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This theory, however, has "withered [,] . . . superseded" by theories of negligence or battery. *Id.*

The physician's duty of due care and the damages available to the plaintiff would be the same, whether an action for nondisclosure sounded in negligence or contract. *Id. See also* 2 *id.* ¶ 18.14, at 560. Since, however, the common understanding of the doctor's obligation to care for patients does not encompass reporting untoward results of the doctor's own mistreatment, it seems unlikely that the implied contract theory can be used to impose a duty to disclose malpractice.

95. For example, an anesthesiologist who performs his or her tasks in the operating room with due care, but observes the primary physician negligently damage an organ, has done nothing negligent vis-à-vis the patient. The anesthesiologist has undertaken to provide only one service—anesthesia—and by competently providing this service, fulfills his or her traditional duty of due care. Similarly, the anesthesiologist's nondisclosure would not constitute traditional misrepresentation. At best, the anesthesiologist would be under a duty to disclose mistakes he or she personally made in providing anesthesia.

96. For a discussion of informed consent, see Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d

informed consent is to enable the patient to make intelligent, knowledgeable choices about his or her treatment.[97] Since "patients are generally persons unlearned in the medical sciences and therefore, except in rare cases, courts may safely assume the knowledge of patient and physician are not in parity,"[98] courts require that physicians inform the patient of his or her diagnosis and prognosis, and explain the risks and benefits of alternative treatments.[99] A patient's need for information is not confined to the period before treatment, however.[100] If malpractice occurs, the patient must decide how to remedy the injury. If a satisfactory nonlegal remedy is impossible, then the patient must decide whether or not to seek compensation in the courts. Information concerning malpractice is critical to both these decisions.

The policies which, along with the primary interest in respecting the patient's autonomy, underlie the doctrine of informed consent also support a duty to disclose. These policies include: instilling a sense of joint venture in the doctor-patient relationship, increasing public visibility of treatment decisions, and prompting professional self-scrutiny with respect to medical deci-

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1, 104 Cal. Rptr. 505 (1972); Hagman, *supra* note 21, at 803-08. In a very narrow range of cases, the doctrine of informed consent can be used directly, rather than by analogy, to impose a duty of disclosure on physicians. The doctrine should apply, for example, where a physician negligently damages an unconscious patient's organ in the course of surgery. If the surgical error requires corrective measures, the physician will need to obtain the patient's informed consent for the repair procedures, as these could not have been contemplated in the initial agreement with the patient. To obtain the second consent, the doctor will need to reveal to the patient that the organ was damaged during surgery.

Unfortunately, the informed consent doctrine can be used to impose a duty to disclose only where: (1) the physician retains post-treatment responsibility for the patient's care; (2) the physician personally carries out remedial measures; and (3) the remedial measures were not included in the original consent agreement with the patient. Because these three requirements do not appear together in many cases, the informed-consent rationale cannot often be used directly to impose a broad duty of disclosure on the primary physician. And, of course, the duty to obtain informed consent runs only to the treating physician, not to the other members of the treatment team.

97. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 242, 502 P.2d 1, 9-10, 104 Cal. Rptr. 505, 513 (1972) (primary purpose of doctrine is to protect patients' autonomy interests).

98. Cobbs v. Grant, 8 Cal. 3d at 242, 502 P.2d at 9, 104 Cal. Rptr. at 513.

99. *Id.* Some courts have also required physicians to inform patients about their own medical skills. *See, e.g.*, Larsen v. Yelle, 310 Minn. 521, 246 N.W.2d 841 (1976) (doctor required to disclose to patient that the doctor lacked specialized skills needed to treat patient and that patient should see a specialist; doctor who fails to do this will be held to specialist's standard of care); King v. Flamm, 442 S.W.2d 679 (Tex. 1969) (physician has duty to refer patient to consultant if physician is unqualified to treat patient).

100. *See* text accompanying notes 62-63 *supra* (risk of further injury if malpractice is not disclosed).

sions.[101] To create a sense of shared enterprise between patient and physician, the patient must be advised of actions taken during the course of the "partnership." Public visibility of treatment decisions will, of course, be heightened by a disclosure requirement. Finally, the imposition of a duty to disclose malpractice may prompt some physicians to evaluate their procedures and skills.

2. Joint Venture or Collective Responsibility

In *Ybarra v. Spangard*,[102] the plaintiff underwent surgery for appendicitis and emerged with severe injury to his shoulder and right arm. The court permitted the use of res ipsa loquitur against all members of the treatment team because the plaintiff had been unable, despite due efforts, to find out which one caused the injury. In a hospital, a patient is treated by a number of different medical personnel with different "contractual" relations with each other.[103] The court said that neither "the number [n]or the relationship of the defendants alone determines whether the doctrine of res ipsa loquitur applies."[104] The crucial fact was that the plaintiff was in the "custody"[105] of these defendants, each of whom owed him a duty of due care, whether or not the particular defendant actually caused the injury or "so neglected [the patient] as to allow injury to occur."[106]

By parallel reasoning, a failure to disclose malpractice to a victim could be seen as a violation of a larger duty of care owed by all members of the treatment team.[107] Nondisclosure could be held to be a form of "neglect" which allows economic or medical injuries to occur. Confronted with a flagrant case of nondisclosure, a court might use the "custodial" rationale formulated in *Ybarra* to impose an affirmative duty to disclose on all members of the treatment team who witness malpractice. Timely disclosure would then be necessary to discharge a treatment team member's duty of care. Permitting the duty to rest on the malpracticing physician alone would be insufficient, since that physician has the greatest incentive not to disclose. For the patient's welfare, other members of the treatment team should be subject to the duty as well.

In *Ybarra*, the plaintiff knew, by the very nature of the injury,

101. *See* J. KATZ, EXPERIMENTATION WITH HUMAN BEINGS 540-608 (1972).
102. 25 Cal. 2d 486, 154 P.2d 687 (1944).
103. *Id.* at 491, 154 P.2d at 690.
104. *Id.*
105. *Id.*
106. *Id.* at 492, 154 P.2d at 690.
107. *See also* notes 134-41 & accompanying text *infra* (discussion of enterprise liability theory utilized in *Sindell v. Abbott Laboratories*).

that his treatment had been improper.[108] In many other cases, malpractice is not so obvious. Given the reluctance of the medical profession to report malpractice, the most effective way to aid the victims in such cases is to mandate disclosure and make nondisclosure actionable.

3. Duty to Warn

In *Tarasoff v. Regents of the University of California*,[109] the California Supreme Court established that a psychotherapist has a duty to warn a third party whom he or she believes the patient is likely to harm.[110] In deciding to impose this duty, the court weighed several factors: (1) foreseeability of harm to the victim; (2) certainty that the victim would suffer injury; (3) closeness of the connection between the plaintiff's conduct and defendant's injury; (4) moral blameworthiness of the defendant's conduct; (5) need for preventing future harm; (6) extent of the burden on the defendant and consequences to the community of imposing such a duty; and (7) availability of insurance to cover the cost of the harm.[111] The court imposed a duty to warn even though the therapist did not have a special or "fiduciary" relationship with his patient's intended victim.[112]

An even better case can be made for a duty to report malpractice than can be made for the duty the court imposed in *Tarasoff*. A special relationship exists between the members of the team and the victim of malpractice; in *Tarasoff* there was no such relationship between the therapist and the victim. Moreover, the seven factors listed by the court all seem to support the creation of a duty to disclose malpractice. It is foreseeable that failure to disclose will cause harm to the victim.[113] The likelihood that this additional harm will occur is substantial.[114] Failure to disclose is causally connected to the harm suffered by the patient.

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108. The patient entered the hospital for treatment of an inflamed appendix and emerged with injuries to his arm and shoulder. *See* text accompanying note 102 *supra*.

109. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

110. *Id.* at 442, 551 P.2d at 347-48, 131 Cal. Rptr. at 27-28. For a general discussion of a physician's liability to third parties, see Hirsh, *Physician's Legal Liability to Third Parties who are not Patients*, 1977 MED. TRIAL TECH. Q. 388.

111. These factors were originally set out in Rowland v. Christian, 69 Cal. 2d 108, 117, 443 P.2d 561, 564, 70 Cal. Rptr. 97, 100 (1968).

112. *See* 17 Cal. 3d at 434, 551 P.2d at 342, 131 Cal. Rptr. at 22.

113. *See* notes 62-63 & accompanying text *supra* (physical harm from nondisclosure); note 66 & accompanying text *supra* (financial harm from nondisclosure).

It is foreseeable, as well, that failure to disclose may harm a malpracticing physician's *future* patients as the physician may repeat the malpractice. Therefore, a physician who failed to report another's malpractice could arguably be liable to patients who are later injured by the malpracticing physician.

114. Although the likelihood of further physical harm will vary from case to case,

Such failure is "blameworthy" behavior.[115] Requiring the primary physician and other members of the treatment team to tell the victim about malpractice would enable the victim to take appropriate action to avoid future physical and economic harm.[116] The burden on defendants would be mitigated by the circumstance that virtually all physicians purchase malpractice insurance, while few victims have sufficient disability insurance to cover the costs of the malpractice.[117]

4. Hospital's Duty to Supervise

A hospital can generally be held vicariously liable for the negligent actions of its employees.[118] Recent cases have gone further and imposed a duty to supervise physicians with visiting privileges[119] as well as hospital staff physicians.[120] Courts have based this duty to supervise on the hospital's obligation to protect patients against incompetent physicians and other medical work-

financial harm in some degree will almost always occur. *See* note 66 & accompanying text *supra*.

115. It might be argued that a doctor's failure to disclose is not blameworthy because nondisclosure is the norm in the medical profession, and what is "normal" cannot be immoral. This equation of morality and common practice is untenable; what is and what ought to be are separate concepts. *See* G. MOORE, PRINCIPIA ETHICA 18 (1903) (describing this "naturalist fallacy"). *See also* Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1971) (rejecting medical community's standard for informed consent); Helling v. Carey, 83 Wash. 2d 514, 519 P.2d 981 (1974) (rejecting medical community's standard for glaucoma tests). Although physicians' special expertise gives some plausibility to the suggestion that they should be permitted to set their own standards regarding difficult technical matters, the development of doctrines such as the common knowledge exception to the expert testimony requirement and objective standards for informed consent demonstrates that this approach has limits.

116. Physical harm can be ameliorated by taking needed medical action; financial harm, by initiating suit.

117. It might be argued that a malpractice victim's private insurance can provide appropriate compensation without the legal battle required to establish malpractice and thereby collect from the physician's malpractice insurance. Patients should not, however, have to bear the cost of protecting themselves against malpractice. Further, few consumers will be able to afford the amount of insurance necessary to protect against medical calamities and the resulting losses. Physicians can afford such insurance. Moreover, shifting the losses resulting from malpractice to the patient would be fair only if it were widely known that physicians injure their patients and then conceal the fact of injury. *See* Calabresi, *The Problem of Malpractice: Trying to Round Out the Circle*, 27 U. TORONTO L. REV. 131, 132 (1977) (disclosure of malpractice risks to public would promote free-market choices with respect to medical care).

118. *See* J. KING, JR., *supra* note 2, at 301-02; 2 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶¶ 16.01, .07.

119. *See, e.g.*, Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972) (hospital held liable when it permitted surgeon with visiting privileges to perform operation while on notice that surgeon was not competent to do so).

120. *See, e.g.*, Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965) (hospital has duty to supervise staff physician), *cert. denied*, 383 U.S. 946 (1966). *See also* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶¶ 16.07-.08.

ers.[121] Because the hospital is in a position to evaluate the competence of physicians who practice there, it is required to exercise care to see that these physicians are, in fact, competent.[122] Once the hospital is on notice of a physician's incompetence, therefore, the physician's status as an independent contractor will not shield the hospital from liability.[123]

The reasons that support liability for hospitals whose management knowingly permits incompetent physicians to practice there also support a duty to disclose malpractice.[124] In our paradigms, as in *Ybarra*, the victim is in the custody of the entire treatment team, whose members share a responsibility for the patient's well-being.[125] Given that in such situations courts may impose a duty to supervise on a hospital, it requires only a small doctrinal step to hold all members of the treatment team liable for nondisclosure. The relationship between the members of the team and the victim is even more direct than the relationship between the hospital administrator and an incompetent surgeon. Members of the team actually witness the malpractice; their liability would not be derivative or vicarious. Rather, it would arise from specific conduct: witnessing flagrant malpractice perpetrated on an unconscious patient and yet keeping silent.

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121. The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses, and internes, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.

Bing v. Thunig, 2 N.Y.2d 656, 666, 143 N.E.2d 3, 8, 163 N.Y.S.2d 3, 11 (1957), *quoted in* Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 332, 211 N.E.2d 253, 257 (1965), *cert. denied*, 383 U.S. 946 (1966).

122. *See* notes 118-21 & accompanying text *supra*. On the same theory, the Hospital Accreditation Board encourages hospitals to exercise some degree of control over doctors and other health care personnel in the hospital.

123. *See* Purcell v. Zimbelman, 18 Ariz. App. 75, 80-81, 500 P.2d 335, 341 (1972).

124. The policies underlying the hospital's duty and the duty to disclose differ in one respect. In the hospital supervision cases, there is a strong public interest in encouraging the hospital to root out incompetent doctors. In disclosure cases, there is no public interest in ejecting from the medical profession an otherwise competent physician who has committed one act of malpractice. There are strong public interests, however, in ensuring that the patient is compensated for the malpractice, in public disclosure of the facts surrounding the malpractice, and in preserving the symbolic value of disclosure.

125. The duty posits a collective undertaking to care for the patient; doctors present as students or observers would not be under a duty to disclose.

5. Duty Not to Impede Rescue

There exists a common law duty not to interfere with, or discourage, rescue.[126] In a typical law school hypothetical, *A* pushes *B*, who cannot swim, off a bridge in full view of a crowd of onlookers. As *B* struggles to remain afloat, *C*, *D*, and *E*, members of the local swim club, announce to the crowd that no one need be concerned; they will save *B*. They swim to *B*'s side, but on recognizing him as a teacher who has given them low grades, they return to shore alone. *B* drowns. Others in the crowd are prepared to testify that had *C*, *D*, and *E* not declared their intention to rescue *B*, they would have done so themselves. Under these circumstances *C*, *D*, and *E*, who ordinarily would have had no obligation to aid *B*,[127] are liable for his death.[128]

This duty not to discourage rescue could be applied to certain instances of medical nondisclosure. It would apply directly to cases in which some members of the treatment team told another member, who appeared disposed to disclose malpractice to the patient, that he or she need not disclose since they had already done so or were on the verge of doing so. If the second member then refrained from reporting the malpractice to the patient, who remained ignorant of it, the first group could then be held liable for "impeding rescue." This liability would result only where at least one member of the treatment team testified that he or she had been prepared to report malpractice to the patient, that other members of the team assured him or her that this was not necessary, and that he or she consequently refrained from disclosing the information. Because the problems of proof with regard to these elements are formidable, the number of malpractice cases in which the discouragement of rescue doctrine could be applied is likely to be small.

There are two ways in which the original doctrine could be extended to impose a much broader duty, however. First, each member of a treatment team or hospital staff might be considered a potential rescuer who had been dissuaded from disclosure by

126. W. PROSSER & J. WADE, CASES AND MATERIALS ON TORTS 407-09 (5th ed. 1971).

127. A person is generally under no duty to aid another in peril, a circumstance that Prosser considers "revolting to any moral sense." W. PROSSER, *supra* note 27, § 56, at 341. *But see* Landes & Posner, *Saviors, Finders, Good Samaritans, and Other Rescuers: An Economic Study of Law and Altruism*, 7 J. LEGAL STUD. 83 (1978) (developing an economic model of rescue and affirmative duties and suggesting that the law develop these and related doctrines when they promote economic efficiency).

128. "But further, if the defendant does attempt to aid him, and takes charge and control of the situation, he is regarded as entering voluntarily into a relation which is attended with responsibility." W. PROSSER, *supra* note 27, § 56, at 343. *See generally* Franklin, note 80 *supra*; Note, *Stalking the Good Samaritan*, note 80 *supra*.

indirect pressures exerted by the team or the hospital.[129] Each individual participating in this conditioning process would become liable for the nonrescue of the patient. Alternatively, the behavior of the team members or hospital staff might be seen as calculated to lull the patient into a false sense of security, thereby deterring the patient from initiating self-rescue.[130] Medical personnel might give the patient the impression that the procedure or operation went smoothly when in fact it did not. If overt, this conduct might constitute active misrepresentation.[131] But the standards required to establish misrepresentation and rescue disablement differ since the policies that underlie the two doctrines differ.[132] Therefore, the discouragement of rescue doctrine might reach situations where no active misrepresentation would be found.[133]

Either type of extension of the rescue duty would result in the imposition of a widely shared duty to disclose upon persons who help to create an atmosphere that inhibits rescue in the form of disclosure. In many respects this result resembles that reached by the California Supreme Court in the "D.E.S." case, *Sindell v. Abbott Laboratories*.[134] In that case, the court held that drug manufacturers bear common liability for injuries caused by improperly tested and marketed products.[135] A plaintiff who could not prove

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129. *See* notes 23, 49-51 & accompanying text *supra* (pressures against disclosure).

130. *See* notes 55-60, 96-101 & accompanying text *supra* (patients need information in order to remedy effects of malpractice).

131. *See* notes 31, 94 & accompanying text *supra*.

132. The tort of misrepresentation was created to punish trickery or unethical bargaining practices, W. PROSSER, *supra* note 27, § 105, at 683-85, while the duty not to impede rescue was designed to punish those who interfere with another's acts of rescue, *id.* § 56, at 343-44.

133. A hypothetical illustrates one such situation: An operating team observes the head surgeon damage a patient's nerve while distracted by a radio sports program. All members of the team, including the head surgeon, agree that malpractice has been committed, but make a pact not to tell the patient. On awakening, the patient notices paralysis but assumes that it is a normal result of the operation. Soon after discharge from the hospital, the patient dies in an automobile accident caused by his impaired coordination from the paralysis. While it might stretch doctrine to conclude that the members of the operating team are guilty of misrepresentation, they clearly failed to take action to protect the patient from danger. Suppose, however, that after the agreement had been struck, one member of the team had approached the others and expressed misgivings, indicating an intention to inform the patient of the malpractice. If the other members of the team threatened the wavering member until he or she agreed not to "rescue" the patient, the impairment of rescue doctrine would apply, even though traditional misrepresentation did not occur.

134. 26 Cal. 3d 588, 607 P.2d 924, 163 Cal. Rptr. 132, *cert. denied*, 49 U.S.L.W. 3270 (1980) (No. 80-172). It is unclear whether the court based its holding on a negligence theory or on a strict liability theory, although the tort of nondisclosure would generally sound in negligence. Nevertheless, cases involving the duty to disclose would share the policy underpinnings of *Sindell*. For example, the *Sindell* court's reasoning echoed that of the cases which allowed malpractice victims to use the tort doctrine of res ipsa loquitur. *See* notes 4, 74, 102-06 & accompanying text *supra*.

135. 26 Cal. 3d at 610-13, 607 P.2d at 936-38, 163 Cal. Rptr. at 144-46. The prod-

that she was injured by the products of a certain pharmaceuticals manufacturer was permitted to sue all of the makers of the product. The court found that if liability was shown, each maker would be liable for a portion of the victim's damages.[136]

The *Sindell* court's reasoning could be applied to medical malpractice cases. The manufacturers' wrongful acts in marketing medicines without adequate disclosure of their dangers can be compared to the medical team's or hospital's actions in concealing a patient's injury. In *Sindell* and in malpractice cases, there are marked disparities between the parties in terms of power,[137] access to information,[138] ability to bear the cost of injury,[139] and fault.[140]

In *Sindell*, the drug companies were required to share the cost of plaintiff's injuries; each company was held liable for that percentage of the plaintiff's damages which corresponded to the company's market share.[141] A court might use this formula to regulate contribution among members of a medical team who conspired to conceal malpractice from the patient. Courts might reasonably hesitate to require that each member of the medical team bear full responsibility for the nondisclosure, since some members occupied positions of greater authority than others. If, for example, a surgeon and four nurses concealed malpractice, causing damage to the patient in the amount of $500,000, a rule that apportioned the damages equally would assess each individual with $100,000 damages. If contribution were required in proportion to team members' respective fees for treating the patient, however, the result would be quite different, and, perhaps, fairer.

The foregoing review of developments in tort doctrine indicates that a court would find a substantial, and growing, body of

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uct in question was diethylstilbesterol (D.E.S.), a synthetic form of estrogen marketed as a drug to prevent miscarriage. *Id.* at 593, 607 P.2d at 925, 163 Cal. Rptr. at 133. D.E.S. was later found to cause cancer in the daughters of women who took it. *Id.* at 594, 607 P.2d at 925, 163 Cal. Rptr. at 133.

136. *Id.* at 612, 607 P.2d at 937, 163 Cal. Rptr. at 145.

137. *Compare* 26 Cal. 3d at 611, 607 P.2d at 936, 163 Cal. Rptr. at 144 (drug companies' power) *with* note 5 & accompanying text *supra* (patients' feeling of dependency on physicians).

138. While the plaintiff was unable to trace the medicine her mother had taken to a particular manufacturer, 26 Cal. 3d at 598, 607 P.2d at 928, 163 Cal. Rptr. at 136, many of the corporate defendants were able to prove their own noninvolvement and have the case dismissed as to them, *id.* at 612, 607 P.2d at 937, 163 Cal. Rptr. at 145. *See also* notes 55-60 & accompanying text *supra* (patients' unequal access to medical information).

139. *Compare* 26 Cal. 3d at 611, 607 P.2d at 924, 163 Cal. Rptr. at 144 (ability of drug manufacturers to bear cost of recovery), *with* note 117 *supra* (doctors are better able to afford malpractice insurance).

140. *Compare* 26 Cal. 3d at 594, 607 P.2d at 925, 163 Cal. Rptr. at 133 (drug companies' fault) *with* note 115 *supra* (nondisclosure of malpractice is blameworthy behavior).

141. *See* 26 Cal. 3d at 611-12, 607 P.2d at 937, 163 Cal. Rptr. at 145.

support for a duty to disclose malpractice. Each of the doctrines discussed is consistent with the proposed duty. Their combined effect suggests that a duty of disclosure is a likely, if not inevitable outcome of current trends in the law of tort.

III. ELEMENTS OF THE DUTY TO DISCLOSE

A. *The Prima Facie Case*

If the courts decide to adopt the proposed cause of action for failure to disclose malpractice, the plaintiff will have to prove the following elements in order to establish a prima facie case against either the primary physician or the other members of the treatment team: (1) that there was clear medical malpractice during treatment; (2) that the primary physician or other members of the treatment team knew of the malpractice; (3) that one or more of these persons failed to advise the victim of malpractice; and (4) that the failure to disclose malpractice caused injury to the victim.

"Clear" malpractice is made an element of the duty in order to guard against overreporting.[142] "Clear" malpractice is malpractice that the primary physician or other members of the treatment team would immediately recognize as such. If it consists of an act, such as leaving a sponge or other surgical instrument inside the patient,[143] or performing a sexual act on an unconscious patient[144]—something that anyone would recognize as malprac-

142. It might be argued that a patient's interest in knowing about conduct which might or might not constitute malpractice is just as great as his or her interest in knowing about "clear" malpractice. Injury to the patient and need for corrective action may occur in "borderline" as well as clear cases. Moreover, if the patient is informed, and can thoroughly investigate the facts, he or she may discover that apparently "borderline" actions in fact constituted clear, actionable malpractice.

"Borderline" cases, however, are cases that a competent attorney might or might not accept. They are cases in which a judge might or might not grant summary judgment, cases in which the victim might or might not prevail. Therefore, many borderline cases, by definition, would fail to produce compensation for the patient; extension of the proposed duty to cover such cases would aid only a limited number of additional patients.

Also, a duty which required physicians to report borderline cases would present greater enforcement problems than would a more limited duty. Where the existence of malpractice was truly a "judgment call," plaintiffs would find it very difficult to show that the conduct in question fell within the "borderline" area. Judicial experience with the common knowledge exception to the expert testimony requirement and objective standards in informed consent cases indicates, however, that courts and juries would be capable of identifying "clear" malpractice.

For these reasons, the proposed duty to disclose malpractice is limited to cases in which no reasonable health care professional, in light of his or her training and experience, could doubt that the act which he or she has seen constitutes malpractice.

143. *See* notes 62, 77 *supra*.

144. *See* the more than 100 cases filed in Sacramento, California, Superior Court in the early months of 1979 against an anesthesiologist who allegedly inserted his penis into the mouths of female patients during surgery. The complaints allege that

tice—then all who witness[145] the act will be under a duty to report it. If the malpractice is evident only to those with specialized training, then only they will have a duty to disclose.[146] In some cases, the physician's acts will constitute malpractice only if certain facts (for example, that the patient is a hemophiliac) are known. In these cases, there is an obligation on the part of the observing physician to make reasonable inquiry to determine whether malpractice has occurred.[147]

After the plaintiff has established clear malpractice, he or she next must show that the persons under a duty to disclose did not notify the plaintiff or the plaintiff's survivors of the malpractice. Notification must take place reasonably promptly, as inordinate delay could compound the victim's damages.[148] The duty to disclose could be discharged in several ways, so long as the victim receives actual or effective notice of the malpractice.[149]

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other treatment team members failed to report the incidents to the disciplinary board or to the patients. Telephone interview with Mr. Vernon A. Leeper, Program Manager, Enforcement Division, California Board of Medical Quality Assurance, Sacramento, Cal. (Mar. 3, 1980). At the time of writing, the physician was reported to be " 'making . . . progress' " in therapy sessions at Atascadero State Hospital, where he was sent as a mentally disordered sex offender. L.A. Times, June 4, 1980, Pt. I at 2, col. 5.

145. It could be proven circumstantially that a given member of the treatment team actually witnessed malpractice by showing that he or she was in the operating room while the event took place, that he or she was in a position to view it, or that his or her duties required that he or she be alert to the actions of the doctor.

146. For example, a subordinate member of a surgical team might not be able to recognize a serious error on the part of the head surgeon, even though the error would be obvious to the surgeon's operating assistants.

147. For example, the observing physician might be required to note whether the patient's chart indicates that the patient is a hemophiliac, or that the left kidney rather than the right (which appeared during the operation to be normal) should have been removed. Similar duties to inquire have been placed on physicians in other contexts. *See, e.g.*, Gates v. Jensen, 92 Wash. 2d 246, 595 P.2d 919 (1979) (physician obligated to conduct further inquiry into patient's condition when symptoms put him on notice that patient might be suffering serious, progressive eye disorder). The *Gates* duty to inquire furthers objectives very similar to those that underlie the proposed duty to disclose: avoiding harm and generating knowledge beneficial to the patient.

148. *See* notes 62-63 & accompanying text *supra* (patient's physical condition may deteriorate if malpractice is not discovered promptly). Disclosure need not be instantaneous: the observing team member may wish to think, consult colleagues, confront the primary physician, or review facts upon which the existence of malpractice depends before informing the patient. But if the observing team member delays disclosure without excuse, he or she will be liable for the injuries suffered by the patient during this period, including pain, suffering, disability, and economic loss.

149. Some persons who observe malpractice may prefer to discharge their duties to disclose by confronting the malpracticing physician and demanding that he or she disclose the malpractice to the patient. Subordinate members of the treatment team may feel more comfortable proceeding up the "chain of command." Or, subordinates fearful of retaliation might discharge their duties by means of an anonymous letter to the patient. A xeroxed copy kept on file would satisfy the requirements of proof.

Can the physician discharge the duty by merely telling the patient he or she

The plaintiff must also show that the failure to disclose caused injury.[150] The clearest cases are those in which the failure to disclose results in additional physical injury or suffering.[151] The passage of time may render corrective measures even more painful or difficult than they would have been had they been carried out more promptly.

In other cases, the plaintiff does not suffer additional physical injury from the nondisclosure but, nonetheless, is prevented from filing suit immediately. In the second paradigm,[152] for example, the victim dies as a result of the malpractice. The failure to disclose negligent treatment to the survivors delays any action that they might bring; the relatives must thus suffer loss without receiving the prompt compensation our legal system is designed to effect. This injury could be described as "loss or postponement of a tort claim."[153] Although it is different in kind from physical in-

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needs more treatment? Suppose a surgeon negligently damages the patient's spleen during surgery. The surgeon might attempt to discharge the obligation to disclose in a variety of ways:

> (1) by telling the patient that his or her spleen needs a further operation;
>
> (2) by telling the patient that his or her spleen needs a further operation because of something that happened during the first operation;
>
> (3) by telling the patient that his or her spleen needs a further operation because of a medical mistake made during the operation;
>
> (4) by telling the patient that his or her spleen needs a further operation because of the surgeon's own malpractice.

Statements (1) and (2) place the patient on notice of his or her medical condition and the need for remedial measures. Thus, they satisfy one of the policy reasons for disclosure. But other equally significant policies, including compensation and deterrence, remain unsatisfied. Therefore, courts should require a statement such as (3) before the duty to disclose is held to be discharged. Courts should not require (4), since such a statement might be viewed as a legal judgment that physicians are not qualified to make. *See* Millett v. Dumais, 365 A.2d 1038, 1041 (Me. 1976) (doctors not required to make disclosure because they need not give their patients "legal advice").

Whatever method of disclosure is used, the person who makes the report should be protected against retaliation or a defamation suit by a conditional privilege. *See* CAL. BUS. & PROF. CODE § 2124.45 (West Supp. 1980) (conditional privilege for physicians and surgeons who report improper conduct of other physicians to Board of Medical Quality Assurance or review committee); W. PROSSER, *supra* note 27, § 114, at 776 (privilege in defamation actions "rests upon the . . . idea, that conduct which otherwise would be actionable is to escape liability because the defendant is acting in furtherance of some interest of social importance"); *id.* at 777 (privilege conditioned on good motives, reasonable behavior, and defendant's belief in the truth of statement); *id.* § 115, at 787-89 (privilege to defame in the "interest of others").

150. If the failure to disclose does not cause injury, the plaintiff does not have a cause of action, no matter how reprehensible the failure is. *See* W. PROSSER, *supra* note 27, § 30, at 143-44.

151. *See* notes 62-63 & accompanying text *supra*.

152. *See* text accompanying note 30 *supra*.

153. This injury can also be described in other ways. *See, e.g.*, W. PROSSER, *supra* note 27, § 128 ("Injurious Falsehood"); *id.* § 129 ("Interference with Contractual Relations"); *id.* § 130 ("Interference with Prospective Advantage").

jury, there is some case authority for the proposition that it is recoverable in tort.[154]

B. *Defenses*

If the foregoing elements are established, the plaintiff will prevail unless the defendant can offer an acceptable defense. At least three defenses are available: (1) contributory or comparative negligence; (2) inability to locate the victim or the victim's relatives; and (3) "therapeutic privilege."

Contributory or comparative negligence[155] is not a "favored" defense to a charge of medical malpractice.[156] Patients are entitled to trust their physicians, particularly when they are vulnerable because of disease or injury.[157] However, if a reasonable person would have known that the injury suffered could only have been caused by medical negligence, then the defendant might be able to prove contributory or comparative negligence.[158] Still,

154. *See, e.g.*, Morris v. County of Marin, 18 Cal. 3d 901, 559 P.2d 606, 136 Cal. Rptr. 251 (1977). In *Morris*, a construction worker became paraplegic when injured at work. He was initially unable to recover for his injuries, however, because his employer, an uninsured licensed contractor, was insolvent. The defendant, County of Marin, had issued a permit to the contractor, without first ensuring, as it was required to do under a county regulation, that the contractor had obtained workers' compensation insurance for its employees. The injured worker sued the county for its failure to follow the regulation, since this failure resulted in the worker's inability to recover from his employer. The California Supreme Court held that the county could be held liable for the worker's loss of his claim against the employer. *See also* J'Aire Corp. v. Gregory, 24 Cal. 3d 799, 598 P.2d 60, 157 Cal. Rptr. 407 (1979) (court used factors enumerated in Rowland v. Christian, 69 Cal. 2d 108, 117, 443 P.2d 561, 564, 70 Cal. Rptr. 97, 100 (1968), to find cause of action when contractor's delay in construction caused economic loss to plaintiff); Brousseau v. Jarrett, 73 Cal. App. 3d 864, 141 Cal. Rptr. 200 (1977) (where doctor misrepresented extent of plaintiff's injuries to insurance company and plaintiff collected only a small settlement as a result, plaintiff had a cause of action against the doctor); Alexander v. Knight, 197 Pa. Super. Ct. 79, 177 A.2d 142, 146 (1962) (doctors "owe their patients . . . a duty of total care . . . that includes and comprehends a duty to aid the patient in litigation") (affirming per curiam on the opinion of the court below, 25 PA. D. & C.2d 649, 655 (1961)); Armstrong v. Morgan, 545 S.W.2d 45, 47 (Tex. 1977) (corporate physician gave inaccurate report of plaintiff's health, with result that plaintiff lost his job; court found cause of action even though plaintiff's only loss was economic, not physical); Rosenthal v. Blum, 529 S.W.2d 102, 105 (Tex. Civ. App. 1975) (where doctor negligently misrepresented plaintiff's injuries to him and he settled with the insurance company for an unreasonably small sum, plaintiff had a cause of action against the doctor), *writ ref'd, n.r.e.*

155. Contributory negligence on the part of the plaintiff bars recovery entirely; comparative negligence results in apportionment of damages. W. PROSSER, *supra* note 27, § 67.

156. *See* J. KING, JR., *supra* note 2, at 284-86.

157. *Id.* at 284-85.

158. For example, a patient who entered the hospital for an appendectomy and emerged from surgery to find that his or her tonsils had been removed would be on notice of the malpractice and could not complain later that members of the treatment team did not report it.

since the patient might not attribute his or her pain and discomfort to malpractice, the defendant physician should be required to show that the injury was so obviously the result of malpractice that anyone would realize without disclosure that malpractice had occurred.[159]

The second defense, attempted disclosure, should succeed only rarely. A defendant who asserts that he or she had attempted to disclose the malpractice but could not find the plaintiff will have to explain why the plaintiff was not told immediately after the treatment.[160] If the plaintiff was not available for notification, the defendant will need to explain why the patient's relatives were not informed.[161]

The only defense likely to succeed with any frequency is that of "therapeutic privilege."[162] In a number of jurisdictions, the duty to obtain informed consent does not exist if disclosure of the risks of treatment could harm the patient.[163] A similar situation might arise when a physician defends his or her failure to disclose malpractice by asserting that disclosure would not have been in the best medical interest of the patient. A cardiac patient, for example, might become so agitated upon learning that the surgeon repaired the wrong coronary artery as to suffer cardiac arrest. An ulcer patient informed of medical errors might suffer recurrence of bleeding.

Several considerations limit the application of therapeutic privilege, however. First, the privilege cannot last longer than the condition that justifies it. Once the patient improves, the malpractice must be disclosed.[164] In informed consent situations, many courts require that when consent cannot be obtained from the pa-

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159. Naturally, if the defendant misrepresented the outcome of the treatment to the patient, the physician would be estopped from asserting the defense—contributory negligence is not a defense to intentional misrepresentation. W. PROSSER, *supra* note 27, § 65, at 426.

160. In a rare case, the doctor's duties might require him or her to leave the scene before the patient awakens, or the patient might unexpectedly leave the hospital before he or she can be notified. *See also* notes 162-65 & accompanying text *infra* (discussion of "therapeutic privilege").

161. It will be difficult for the defendant to give such an explanation since most physicians and hospitals require patients to complete financial responsibility forms that contain the names and addresses of immediate relatives.

162. The doctrine of "therapeutic privilege" permits a physician to refrain from disclosing matters related to a patient's diagnosis, prognosis, or treatment if he or she has good reason to believe that disclosure will cause serious harm to the patient.

163. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

164. Many legal rules are similarly limited in application. *See, e.g.*, 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 8.09 nn.27, 31 (emergency consent doctrine limited to duration of emergency and authorizes physician to treat only the condition that produced emergency); *id.* ¶ 8.06 ("legal rule [that expert testimony must be limited to area of malpractice] ceases when the reasons for it cease").

tient, because of risk to his or her health, the physician must notify a close relative and obtain his or her consent.[165] Applied to the disclosure context, this would require that the medical team notify a close relative that malpractice has occurred. The relative could then take medical or legal action to protect the patient's interest. These limitations, which courts have applied in pretreatment situations, would help ensure that the defense of "therapeutic privilege" would not be applied so broadly as to nullify the duty to disclose.

IV. POSSIBLE OBJECTIONS TO THE DUTY TO DISCLOSE

There are several possible objections to the proposed duty to disclose malpractice to the patient. Opponents of the duty could argue: (1) that the duty would destroy doctor-patient trust; (2) that the duty would weaken trust among health care professionals; (3) that the duty would be ineffective; (4) that the duty would encourage false reporting; (5) that the duty would result in higher medical fees; (6) that the duty would discourage doctors from entering specialized practice; and (7) that the establishment of a duty to disclose should be left to the legislature.

A. *Doctor-Patient Trust*

It might be argued that imposing a duty on physicians to disclose malpractice would harm doctor-patient trust, either directly or indirectly. An erosion of trust might stem from the increased number of malpractice actions that would be filed as a result of victims' becoming aware of the malpractice they have suffered, as well as the publicity resulting from these suits. But blind trust—trust that persists only because the public does not know relevant facts—is scarcely deserving of legal protection. The public is entitled to know why trust should exist, and to repose the degree of confidence in the medical profession that it deems warranted.[166]

Alternatively, it could be argued that trust might be damaged

165. *See* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.) (notification of relatives required when patient is unconscious and unable to consent), *cert. denied*, 409 U.S. 1064 (1972); 2 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶¶ 22.02, .09. *But see* Karp v. Cooley, 349 F. Supp. 827 (S.D. Tex. 1972) (disclosure to family not required), *aff'd*, 493 F.2d 408 (5th Cir.), *cert. denied*, 419 U.S. 845 (1974); Nishi v. Hartwell, 52 Hawaii 188, 473 P.2d 116 (1970) (disclosure to family not required).

166. The idea that a free flow of information stimulates public trust underlies a number of legislative reforms of the last decade. *See, e.g.*, City of Davis v. Coleman, 521 F.2d 661, 670 (9th Cir. 1975) (explaining purpose of environmental impact statement); Sierra Club v. Morton, 510 F.2d 813, 819 (5th Cir. 1975); Freedom of Information Act, 5 U.S.C. § 552 (1976); National Environmental Policy Act of 1969, 42 U.S.C. § 4332 (1976) (provides for filing of environmental impact statements in order to provide public with information about proposed governmental actions affecting the environment). For a discussion of the connection between information flow and po-

simply because of the symbolic effect of adopting a rule of disclosure, which might suggest to the public that doctors, as a group, are not to be trusted. It seems far from certain that this will result, however. As matters now stand, patients cannot rely on any member of the treatment team to report malpractice. Although many patients are unaware of this, others have become skeptical of the medical profession, perhaps because of personal experiences, friends' experiences, or exposure to the patient-consumer movement.[167] These patients regard physicians warily, seeing malpractice in every unfavorable outcome of treatment.[168] The existence of an affirmative duty to disclose should strengthen, not weaken, the trust that these patients have in their physicians. If patients can expect an observer to come forward even if the primary physician fails to do so, they will be less likely to resort to surreptitious inquiries, shopping for a second physician who will accuse the first of malpractice, or filing lawsuits to discover what happened.

Even if public trust is damaged to some degree, a number of considerations suggest that this effect might be worth incurring. First, a society committed to political openness has reason to distrust an ends-justify-the-means argument for ignorance. Indeed, we have implicitly rejected this argument in the case of politicians and corporate directors, who are required to make financial disclosures even though facts might come to light that could bring an entire profession into disrepute. Further, knowledge of the extent of unreported medical negligence might serve as a stimulus for needed reform. Thus, even if undeserved trust improved the quality of medical services to some extent, this might not be a sufficient reason for fostering it.

B. *Trust Among Medical Professionals*

It could also be argued that a duty to disclose would damage

litical openness, see Delgado, *Active Rationality in Judicial Review*, 64 MINN. L. REV. 467, 492-99 (1980).

167. For the view that anger and a sense of betrayal on the part of the patient trigger many malpractice suits, see 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 5.01. Recognizing this, a number of teaching hospitals have recently developed "risk management" teams, whose objective is to identify promptly instances of malpractice committed by physicians in the facility, approach the patient and discuss the situation honestly and openly, and offer to cancel charges and provide supportive services as necessary. Interview with Angela Holder, Counsel for Medicolegal Affairs, Yale-New Haven Hospital, in New Haven, Conn. (Sept. 28, 1979). Prompt disclosure of malpractice, then, far from stirring up malpractice actions, may reduce their number.

168. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶¶ 5.01, .06 ("[t]he mind [of the patient] naturally feeds upon uncertainties rooted in a lack of understanding" resulting from a less than forthright explanation, or a "deficient or missing explanation").

trust and confidence among health care professionals, as each might come to regard his or her colleagues as potential informants. In evaluating this objection, it is important to recall that the medical profession discourages disclosure of malpractice.[169] The trust that currently exists among doctors and between doctors and nurses thus tends to protect incompetent professionals at the expense of their patients.[170] Those who practice medicine with due care do not need—and should not want—such protection.

It might be urged that even competent and caring professionals have reason to fear a requirement of disclosure. An attitude of constant watchfulness among, for example, the members of an operating team, could impair their rapport and ability to work together.[171] The truth of this assertion is far from self-evident, however. Police officers are required to work in close cooperation under conditions of great stress;[172] yet few would urge that police officers be relieved of the duty to report graft or brutality on the part of fellow officers.[173] There seems little reason to treat physicians differently.

Another variant of this objection is the argument that a duty to report malpractice would harm doctor-doctor relations because colleagues would be required to disclose the rare slip of an otherwise competent, even superb, physician. It could be argued that this would place an intolerable strain on physicians who are already keenly aware of their own fallibility.[174] This objection is misconceived, for the malpractice standard does not require perfection; it merely requires that physicians' practices not fall below the norm in their communities.[175] Less than ideal treatment,

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169. *See* notes 38-54 & accompanying text *supra*.

170. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 5.03 (doctors frequently place loyalty to colleagues above honesty to patient, refusing to tell patient that he or she has suffered malpractice at the hands of another physician).

171. It might be argued that an attitude of skeptical alertness on the part of team members could inhibit their teamwork or that the quality of medical care might be lowered if subordinate members of the treatment team paid more attention to possible mistakes on the part of the primary physician than they paid to the needs of the patient.

172. *See* S. REID, CRIME & CRIMINOLOGY 306-14 (1976) (stress of police officers' work results in group solidarity).

173. *See* Packer, *Policing the Police*, NEW REPUBLIC, Sept. 4, 1965, at 17 (great public interest in controlling police misconduct). *See also* P. CHEVIGNY, POLICE POWER: POLICE ABUSES IN NEW YORK CITY (1969); J. WILSON, VARIETIES OF POLICE BEHAVIOR (1968).

174. *See* E. FREIDSON, DOCTORING TOGETHER 131 (1975) (describing physicians' consciousness of fallibility: "[T]here but for the grace of God go I"); 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 2.26 (honest physicians recognize their own limitations and take steps to minimize the impact of those limitations on patients); *id.* ¶ 2.03 (above-average practitioner possesses professional humility); W. NOLEN, *supra* note 1, at 144-45, 147, 151-53, 165.

175. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 8.03 (malpractice stan-

medical judgment that in retrospect could have been better, the patient who unexpectedly dies—none of these is necessarily actionable. Only where the physician's error constituted clear malpractice would observing colleagues have a duty to report.

C. *Effectiveness of a Duty to Disclose*

1. Efficacy of the Duty

It might be argued that the proposed duty to disclose malpractice would not be effective. In order for the imposition of such a duty to deter malpractice, some nondisclosure actions must be brought, and, in order for such actions to be brought, malpractice victims must have some way of learning that they have a cause of action for nondisclosure. The objection could therefore be raised that a patient could not sue for nondisclosure of malpractice until he or she knew that malpractice had occurred, and the patient could not learn of the malpractice if the medical team kept quiet about it.

Some patients will learn of the malpractice by chance;[176] those who do will benefit from the new cause of action.[177] And, other interests, including the symbolic message conveyed by adopting the cause of action, support the imposition of a duty to disclose.[178] But, if doctors frown on those who criticize colleagues in public, resist service as expert witnesses in malpractice cases, and tolerate physicians whose abilities are markedly substandard or impaired, how can it be expected that they will conform to a duty to disclose? First, many physicians are idealistic,[179] law-abiding citizens for whom a *legal* duty to disclose malpractice would make a difference. Even if this were not true of every member of the treatment team, the patient would be adequately protected if only one member were to come forward. Recent developments in informed consent and in the duty to warn have imposed legal obligations on physicians that run counter to their

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dard is failure to exercise reasonable skill or care); *id.* ¶ 8.05-.06 (emergence of objective standards of care); *id.* ¶ 8.06 (demise of locality rule and trend toward uniform national standards).

176. *See* text accompanying notes 17-18, 23 *supra*.

177. So long as there is no affirmative duty to disclose, a malpracticing physician motivated only by self-interest will probably *not* disclose. Without the fear of additional liability for failure to disclose, such a physician will simply remain silent and hope that his or her malpractice is not discovered. Under current law, the most that the physician can lose by this course of action is the amount of damages he or she would have lost had the malpractice come to light immediately. And, by nondisclosure, the physician retains the use of this money until the malpractice is discovered.

178. *See* notes 186-88 & accompanying text *infra*.

179. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 2.02 (many physicians attracted to the practice of medicine for humanistic reasons).

professional practices and instincts.[180] A growing number of exceptions to the doctor-patient and therapist-patient privileges[181] have also required that physicians conform to new and unfamiliar professional practices.[182] Yet, after a period of initial grumbling and opposition, the medical community has accepted each of these legal innovations.[183] It seems likely that this will also occur in the case of a judicially imposed duty to disclose malpractice.

Thus, as the duty becomes accepted, physicians desiring to resist professional pressures and disclose malpractice to the patient will be able to point to legal authority to support their decisions to disclose. Also as mentioned earlier, the recognition of a legal duty to disclose would make possible, in a way a moral duty would not, the development of remedies for retaliation against those who come forward.[184] This in turn would encourage greater reporting.

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180. The duty to obtain informed consent runs counter to physicians' notions of professionalism and to their "right" to practice medicine as they see fit. The duty to warn conflicts with psychotherapists' policies against disclosing confidential material imparted by patients.

181. *See, e.g.*, Fleming & Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CALIF. L. REV. 1025, 1033-35 (1974) (limitations placed on psychotherapist privilege); Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 176, 181-83 (1960) (recently adopted rules narrowing scope of medical privilege).

182. *See, e.g.*, CAL. EVID. CODE § 1014, Legislative Comment (West 1975) (psychoanalysis and psychotherapy depend on the "fullest revelation of the most intimate and embarrassing details of the patient's life"; without protection of these confidences, psychiatrists and psychotherapists will be unable to treat patients successfully); Fleming & Maximov, *supra* note 181, at 1031-33 (therapists feel sense of obligation to protect patients' confidences).

183. The doctrine of informed consent has been widely adopted by American jurisdictions, 2 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶¶ 22.01, .03, .08, and has been accepted as a fact of life by most medical practitioners. Indeed, there are indications that physicians and hospitals overprotect themselves against informed consent suits with elaborate consent forms. Interview with William Winslade, Director, Program in Medicine, Law and Human Values, UCLA, in Westwood, Cal. (Mar. 17, 1980).

Although there has been no formal study of compliance with the *Tarasoff* duty to warn, knowledgeable observers believe that psychotherapists are complying with the duty. *Id. See also* Comment, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effect of* Tarasoff, 31 STAN. L. REV. 165, 185 (1978).

Doctors and therapists also seem to be complying with subpoenas and discovery orders made pursuant to an exception to medical or therapeutic privilege. *But see In re* Lifshutz, 2 Cal. 3d 415, 420, 426-27, 467 P.2d 557, 559, 563-64, 85 Cal. Rptr. 829, 831, 835-36 (1970) (psychiatrist held in contempt for refusal to obey discovery orders). *See also* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 1.05 (medical profession beginning to support concept of medical defense panels whose purpose is to procure information concerning potential malpractice claims and decide which are meritorious); *id.* ¶¶ 6.02-.03 (efforts of medical community to abolish inferior techniques and eliminate incompetent colleagues).

184. *See* note 53 *supra* (need to protect informants against retaliation); note 149 *supra* (methods of protection).

Finally, some observing physicians may refrain from approaching the patient for fear that the primary physician may have been on the verge of doing so and that his or her own hasty disclosure will appear unseemly. The observing physician may personally dislike the individual responsible for the malpractice, or perceive him or her as a competitor. The physician may, therefore, hesitate to make a report for fear of seeming self-serving and vindictive. A duty to disclose, running to all members of the treatment team who observe the malpractice, avoids these problems. A partial privilege will protect the person who makes disclosure in good faith.[185] The disclosing physician need not worry about the timing of his or her report or about "upstaging" the primary physician; unless they are assured that the patient has, in fact, been notified, all members of the treatment team have a duty to report the malpractice promptly.

Even if the duty to disclose is not universally obeyed—what legal norm is?—reasons remain for its adoption. First, it has symbolic value.[186] Just as development of the informed consent doctrine communicated an important message about patients' autonomy and their rights to participate in decisions concerning treatment,[187] a requirement of disclosure would constitute a significant expression of concern for the post-treatment well-being of patients and their entitlement to information about procedures performed on their bodies.[188] In addition, there is the matter of

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185. *See* note 149 *supra*.

186. *See* Olmstead v. United States, 277 U.S. 438, 485 (1928) (Brandeis, J., dissenting) ("Our government is the potent, the omnipresent teacher. For good or for ill, it teaches the whole people by its example."), *overruled*, Katz v. United States, 389 U.S. 347, 352-53 (1967).

Characterization of the tort of nondisclosure as intentional or negligent will affect the way in which courts view the symbolic dimension of nondisclosure. In the absence of tangible physical or economic harm, a patient might recover for the affront of not being told that he or she had suffered malpractice, but only if nondisclosure is characterized as a tort of intent. Nominal damages for infringement of dignity are recoverable most readily when the action sounds in intentional tort. *See* D. DOBBS, HANDBOOK ON THE LAW OF REMEDIES § 7.3, at 528-29 (1973); W. PROSSER, *supra* note 27, § 8, at 30 & n.21, § 9, at 35-37, § 10.

187. *See* Schloendorff v. New York Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."), *overruled on other grounds*, Bing v. Thunig, 2 N.Y.2d 656, 665-67, 143 N.E.2d 3, 8-9, 163 N.Y.S.2d 3, 10-12 (1957); J. KATZ, EXPERIMENTATION WITH HUMAN BEINGS 540-68 (1972) (autonomy interest is primary rationale for doctrine of informed consent). *See also* note 96 *supra*.

188. In addition to their interests in compensation and in remedial medical measures, patients have an interest in simply knowing what has happened to them during treatment. Imagine, for example, a case in which the remorse-stricken doctor, aware of his or her wrongdoing, arranges to transfer funds to the patient's bank account, anonymously, and with no explanation other than an unsigned letter stating that the deposit is intended to settle an old score. The physician has ascertained that this amount is an appropriate settlement by consulting court records in similar cases. At

compensation. Where obvious malpractice occurs, yet no member of the treatment team reports it to the patient, the patient may suffer grave physical or economic harm.[189] If, as a result of a chance event the patient discovers the malpractice years later, recovery against the primary physician may prove impossible because of his or her retirement, death, or departure from the jurisdiction. Even if redress against the malpracticing physician is possible, delay in bringing the action may have compounded the harm to the patient or to his or her family.[190] Breach of a duty to disclose makes the increased harms compensable[191] and gives the injured victim a larger number of potential defendants and causes of action.[192] Thus, symbolic and practical reasons militate in

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the same time the physician resolves never again to commit a similar error. Although deterrence and compensation interests have been satisfied, does the patient have an interest in requiring the doctor to disclose what happened during surgery? The patient's interest could be seen as part of the expanding notion of a "right to know," articulated by commentators and recognized by a few courts. *See, e.g.*, Emerson, *Legal Foundations of the Right to Know*, 1976 WASH. U. L.Q. 1. Or, the patient's interest could be seen as a reciprocal right to the right of privacy: the right to know intimate information about oneself that one's right of privacy protects from the prying eyes of others. *Cf.* R. BURT, *supra* note 57, at 117-19. The patient's right could also be viewed as a corollary of the physician's duty to obtain informed consent. Thus, patients would be entitled to receive information about what had been done to them, just as they are now entitled to know what may happen to them in the future. Finally, the patient's right could be seen as an aspect of protection for the concept of personhood. A sense of personhood, according to some writers, is dependent upon continuity of experience and consciousness of self. *See, e.g.*, Comment, *The Limits of State Intervention: Personal Identity and Ultra-Risky Actions*, 85 YALE L.J. 826 (1976).

189. *See* text accompanying notes 62-67, 150-54 *supra*.

190. *See* notes 62-67, 150-54 & accompanying text *supra*.

191. A small number of cases have held that economic harms can be compensated, as consequential damages, in an action brought against the primary physician for the original malpractice. *See* cases cited in notes 92-93 *supra*. These cases require, however, that the primary physician be available as a defendant when the malpractice comes to light.

192. The adoption of a duty to disclose would alter the types and measures of damages available to malpractice victims as follows:

A. DAMAGES AVAILABLE FOR UNDISCLOSED MALPRACTICE *BEFORE* ADOPTION OF PROPOSED DUTY.

(1) *From the malpracticing physician.* The plaintiff can recover for the original malpractice. If there are additional damages resulting from the delay, the plaintiff can recover for those that are physical and are directly attributable to the original malpractice. Economic damages are probably not recoverable.

(2) *From members of the treatment team who observed the malpractice and kept silent.* The plaintiff can recover nothing.

B. DAMAGES AVAILABLE FOR UNDISCLOSED MALPRACTICE *AFTER* ADOPTION OF PROPOSED DUTY.

(1) *From the malpracticing physician.* The plaintiff can recover for the original malpractice, as well as for any harm, physical or economic, resulting from the nondisclosure.

(2) *From members of the treatment team who observed the malpractice and*

favor of recognition of the proposed duty, even if it is only partially effective in reforming conduct.

2. Counterefficacy of the Duty

It could also be argued that a duty to disclose would be counterproductive—that it might alter physicians' conduct in undesirable ways. Because of concern over the possibility that a subordinate might report directly to the patient in the event of malpractice, physicians might seek out subordinates for their malleability rather than on the basis of their competence. As a result, the quality of medical services patients receive might deteriorate.

A number of factors suggest that this result would be unlikely. First, at many hospitals the physician has little choice with respect to the composition of the treatment team; it is supplied by

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kept silent. The plaintiff can recover for any damages, economic or physical, resulting from nondisclosure, including loss of the original claim.

Another issue that must be considered in connection with damages for nondisclosure is indemnification and contribution. *See* W. PROSSER, *supra* note 27, §§ 50-51. A team member who is sued for nondisclosure might file a claim against the malpracticing physician for indemnification on the theory that the malpracticing physician's misconduct had rendered the team member liable. Or, the team member might file a claim for contribution, on the theory that team members should apportion the damages according to their share of responsibility for the nondisclosure. The team member's claim against the malpracticing physician would not accrue until he or she was sued by the patient; hence, if brought promptly, it would generally not be barred by any statute of limitations that might bar a suit by the patient against the surgeon. *See id.* § 50, at 309; C. WRIGHT, HANDBOOK OF THE LAW OF FEDERAL COURTS § 76, at 377 (3d ed. 1976).

"Joint action" is required to bring the doctrine of contribution into play. This requirement has been deemed satisfied when persons act in pursuit of a "common plan or design." W. PROSSER, *supra* note 27, § 46, at 292. Joint action may consist of active participation, cooperation, encouragement, aid lent to the tortfeasor, or ratification or adoption of the tortfeasor's acts. *Id.* Express agreement is unnecessary; a tacit understanding to proceed toward a common objective—such as concealment of malpractice—will suffice. *Id.*

Indemnity has been permitted where one tortfeasor, through his or her active conduct, creates a danger to a plaintiff, and the other tortfeasor merely fails to discover or remedy the danger. *Id.* § 51, at 312. Indemnity generally has been permitted where there is a "great difference" in the fault of the tortfeasor. *Id.* at 313.

Cases stemming from nondisclosure of malpractice would seem to meet the requirements for contribution, but not for indemnification. Moreover, policy considerations support allowing contribution, but not indemnification, in such cases. For example, permitting team members to recover against the malpracticing physician through indemnification decreases the pressure on the team member to come forward, since *all* liability is passed to the malpracticing physician. On the other hand, the malpracticing physician is more culpable than the team member in that he or she committed the original malpractice and then failed to disclose; the team member merely failed to disclose. Also, the malpracticing physician will probably be the deeper pocket of the two defendants. Thus, in most cases, contribution should be permitted but indemnity denied.

the hospital.[193] The hospital would, of course, be anxious to avoid liability for negligent supervision,[194] and hence would be strongly motivated to hire competent personnel. It seems unlikely, as well, that a physician who practices in a small office or clinic would prefer to run the risk of multiple suits arising from the hiring of incompetent assistants in order to gain occasional protection in a suit resulting from his or her own malpractice. Because of the great risk inherent in hiring incompetent but loyal associates and the uncertainty of the gain, few physicians would be tempted to avoid the responsibility to disclose malpractice in this fashion.

It might also be argued that, aside from the impact that a duty to disclose would have on physicians, it is better for patients not to know that they have been the victims of malpractice. Patients need to know that they have suffered malpractice, however, in order to seek further treatment or to sue for relief. Moreover, a patient may experience a severe shock if he or she learns of the malpractice accidentally.[195] Thus, the "ignorance is bliss" argument supports, if any, only a very limited "therapeutic privilege" exception to the duty to disclose.[196]

D. *Encouragement of False Reporting*

It could be argued that a duty to disclose might be used vindictively by certain physicians to punish mavericks, nonconformists, or physicians who have spoken out against the medical establishment. It could also serve as a weapon to eliminate individual physicians' rivals. It might be asserted that, if the informant can argue that he or she is merely complying with a legal duty, there will be a great temptation to use the duty to achieve improper ends. A person who files a report in bad faith commits defamation.[197] That the informant would be protected by a conditional privilege[198] only if the report is made in good faith should deter the filing of malicious reports. Moreover, professional disapproval of in-group criticism provides additional protection against

193. Interview with William Winslade, Director, Program in Law, Medicine, and Human Values, UCLA, in Westwood, Cal. (Mar. 18, 1980).

194. *See* notes 118-23 & accompanying text *supra* (hospital has duty to supervise personnel).

195. *See, e.g.*, notes 13-18 & accompanying text *supra* (patient suffered serious mental breakdown when she learned of malpractice through newspaper account, 18 months after it occurred).

196. *See* notes 162-65 & accompanying text *supra*.

197. Defamation is the dissemination of matter that is false and injurious to the reputation of the person defamed. *See* 2 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 18.13 (discussing damages in action for defamation); W. PROSSER, *supra* note 27, § 111, at 737-44.

198. *See* discussion of conditional privilege in note 149 *supra*.

abuse of the duty to report.[199]

E. *Effect on Medical Fees*

One reason to impose a duty to disclose on the members of the treatment team and the primary physician is that this will spread the cost of malpractice more equitably than it is spread at present.[200] Currently, patients as a group are able to recover for only some, not all, cases of clearcut malpractice. Cases that do not come to the attention of the victim or his or her survivors will remain uncompensated forever. The victim must absorb the losses, while the physician escapes liability altogether.[201] As a society, we have already decided that malpractice is compensable, and that patients who suffer from seriously deficient medical care are entitled to recover from the doctor. Every malpractice action increases the cost of practicing medicine and thereby contributes directly or indirectly to higher medical fees. High fees are a severe problem, but the solution should not be to deny the victim of malpractice adequate compensation. Rather, ways must be found to eliminate incompetent doctors who are responsible for a large proportion of malpractice cases.[202]

F. *Effect on Specialization*

Higher malpractice premiums do not appear to prevent physicians from specializing,[203] probably because the monetary rewards for most forms of specialized practice are still extremely attractive. And, if a small number of physicians is in fact deterred from entering specialties by the prospect of a duty to disclose and the resulting increase in the rate of discovery of medical malpractice, this result is perhaps desirable. Recent studies of the distri-

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199. *See* notes 48-51 & accompanying text *supra*.

200. *See* W. PROSSER, *supra* note 27, § 5, at 22 (desire to spread loss is a reason to regard certain acts as torts).

201. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 1.07.

202. *See* Dornette, *Role of the Healing Arts Licensing Board in the Current Medical Malpractice Crisis*, J. LEGAL MED., Mar. 1976, at 9 (inept practitioners responsible for large part of malpractice crisis); *id.* at 11-12 (possible responses to problem of the "impaired" physician); Miike, *Public Policy Directions in Medical Malpractice*, J. LEGAL MED., Apr. 1976, at 9 ("There may be so many incompetent physicians that one's life is in danger every time one sees a physician or enters a hospital.").

Adoption of the proposed duty might well encourage hospitals to take action on this problem. If hospital workers disclose instances of malpractice which they observe, the hospital will face an increased number of suits, together with the negative publicity such suits generate. If the hospital employees do *not* disclose, they may be sued for nondisclosure. In either case, the hospital will have an incentive to discharge or to deny visiting privileges to physicians who are likely to cause such suits.

203. *See, e.g.*, Curran, *Law-Medicine Notes, Malpractice Claims: New Data and New Trends*, 300 NEW ENG. J. MED. 26, 27 (1979); Presser, *Factors Affecting the Geographic Distribution of Physicians*, J. LEGAL MED., Jan. 1975, at 12.

bution of medical services reveal that most specialties are oversubscribed[204] and that more primary care physicians in general practice are needed.[205]

G. *Should a Duty to Disclose be Left to the Legislature?*

Some might argue that it is preferable for the legislature, rather than the courts, to consider the various interests at stake and decide whether or not to impose a duty of disclosure. This would, of course, be desirable.[206] The problem is that the medical profession is far better organized and far better able to influence the outcome of legislative struggles than are its patients.[207] As a result, legislation that provided for mandatory disclosure of malpractice would be highly unlikely to pass.[208] Further, the pro-

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204. *See* sources cited in note 203 *supra*; W. NOLEN, *supra* note 1, at 209 (most specialists located in big-city teaching hospitals).

205. *See, e.g.*, 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶ 2.05; Colwill, *Primary Care Education in Multiple Specialties*, 299 NEW ENG. J. MED. 657 (1978); Perkoff, *General Internal Medicine, Family Practice or Something Better*, 299 *id.* at 654; Relman, *Who Will Train All Those Primary-Care Physicians?*, 299 *id.* at 652; Scheffler, Weisfield, Ruby & Estes, *A Manpower Policy for Primary Health Care*, 298 *id.* at 1058 (1977); Thier & Berliner, *Manpower Policy: Base it on Facts, Not Opinions*, 299 *id.* at 1305.

206. More desirable still, of course, would be for the legislature to find more sweeping solutions to the malpractice crisis, such as national health insurance or a national health service. Therefore, another objection to the proposed duty is that, while it might offer symbolic value and aid patients in particular cases, the duty's promulgation might slow the movement toward fundamental change in the structure of medical care. In opting for the short-term partial measure, long-term and more complete remedies might be postponed or foreclosed. The objection thus balances the gains for today's patients that would result from adopting the duty against possibly greater gains for tomorrow's patients if the duty is not adopted and more sweeping reforms are instituted instead.

First, it is highly uncertain that a duty to disclose malpractice will slow the search for more fundamental reforms. Rather, knowledge of the true extent of malpractice is likely to increase the pressure for reform. Also, the forces opposing the restructuring of medical services are powerful, and fundamental reforms may never be effected. Sacrificing a duty of disclosure in order to hasten reforms that may never materialize trades a tangible benefit for one that is merely speculative. Even if the duty does delay other measures, this may be outweighed by the benefit the duty confers on patients whose injuries otherwise would have gone uncompensated. Short-term gains may thus outweigh long-term losses. For now, medical malpractice actions are the lone avenue by which a victim of improper medical treatment may obtain relief. Therefore, it seems advisable not to wait for uncertain future reforms, but to extend and improve the approaches now available to patients so as to afford the most effective, fair form of relief possible.

207. *See, e.g.*, M. FRIEDMAN, CAPITALISM AND FREEDOM 143 (1962); R. KUNNES, YOUR MONEY OR YOUR LIFE 59-60 (1971); Montange, *Consumer Protection and Professional Services*, J. LEGAL MED., May 1976, at 23. *See also Malpractice: RX for a Crisis*, TIME, June 16, 1975, at 49-50 (legislative responses to "malpractice crisis" were aimed at protecting physicians from malpractice actions).

208. Could it be argued that the legislature has already "occupied the field" by their attempts to address aspects of the malpractice problem? It might be asserted that the legislature carefully considered the entire question of malpractice before

posed duty is a logical extension of judicial tort doctrine created over decades of experience with medical malpractice cases.[209] Thus, since social and political reasons exist for judicial activism in this area, and the proposed duty is based on judicially created tort doctrines, courts would not be preempting a primarily legislative function by creating a duty to disclose malpractice.

CONCLUSION

Innovations in tort theory have provided much needed aid to plaintiffs faced with the "wall of silence" in medical malpractice cases. Unfortunately, the benefits they provide inure only to individuals who realize they have been the victims of medical malpractice. Other victims, equally deserving of recompense, fail to demand it because they have no reason to suspect that they have suffered from deficient medical care. If the primary physician and other members of the treatment team conceal malpractice, the victim may believe that his or her pain, debilitation, or loss of function are merely unfortunate results of the operation or procedure. A duty to disclose malpractice is necessary because the medical profession does not regulate itself effectively, discourages the reporting of malpractice to patients, and erects formal and informal barriers to patients' access to information. The proposed duty to disclose malpractice is consistent with current trends in tort law, such as the development of the doctrines of informed consent, collective responsibility, duty to warn, and duty to supervise. It would remedy a serious imbalance in the physician-patient relationship, as well as enable some victims of malpractice to obtain relief who would otherwise be unable to do so. It would give tangible expression to the moral imperative that professionals who injure their clients must inform them of the injury. It is a remedy to which courts and legislatures should give serious attention.

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drafting a statute which, since it does not contain a duty to disclose, stands as a legislative statement that such a duty should not be imposed.

This line of reasoning is flawed, however. First, no legislature has given medical malpractice the extensive treatment that might conceivably give rise to a presumption that its silence on the question of a duty to disclose was deliberate. A review of legislative enactments contained in D. LOUISELL & H. WILLIAMS, note 2 *supra*, suggests that statutory treatment in this area tends to be piecemeal, with reforms and amendments coming at irregular intervals in response to specific needs. Many states leave development of malpractice doctrine largely to the courts. *See* 1 D. LOUISELL & H. WILLIAMS, *supra* note 2, ¶¶ 13.01-.64 (statute of limitations doctrine).

Moreover, even extensive statutory treatment of medical malpractice would not necessarily imply that a legislature thought about a duty of disclosure and rejected it. It would be equally likely that the legislators did not think about such a duty at all.

209. *See* notes 68-141 & accompanying text *supra* (developments in tort law suggest that a duty of disclosure is feasible). The closest analogue to the duty to disclose is informed consent; indeed, the proposed duty could be seen as an extension of the judicially created doctrine of informed consent.