PHYSICIAN COUNTERSUITS—A SOLUTION TO THE MALPRACTICE DILEMMA?

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Following a period of relative passiveness among physicians, during which most lived in trepidation of a malpractice action being filed against them, there emerges a new era of physician activism. This activism has taken the form of countersuits, based most commonly upon malicious prosecution either as a single cause of action or in conjunction with abuse of process or defamation suits. This Article will explore the derivations and positive and negative effects of malpractice suits, the possibilities of a physician being wrongfully sued, the potential ways in which the doctor can counterattack, and the effectiveness of countersuits in solving the malpractice problem.

I. Myths and Realities of Malpractice

A professional paranoia has developed among doctors who appear, according to one authority, to believe that doctors are sued on a regular basis, that plaintiffs win easily, that the verdicts against professionals are universally large and that the sued physician's reputation is damaged.[1] None of these suppositions can be confirmed statistically.[2]

A ten year survey in Maryland of 2,045 physicians showed 84% had never been sued, 14% had been sued once and only 2% had been sued more than once.[3] At least one authority believes that a majority of the malpractice actions are brought against doctors who are above the median in experience, standing and reputation;[4] and it seems that in some instances being sued has become a status symbol as lawsuits happen in even the best of medical practices.[5]

II. Sources of the Malpractice Action

Medical "[m]alpractice may be defined as the failure upon the part of a physician or dentist properly to perform the duty which devolves upon him

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1. Markus, *Attorney's View*, Exploring the Medical Malpractice Dilemma 3, 4 (C. Wecht ed. 1970).

2. *Id. See also* U.S. Dep't of Health, Educ. and Welfare Rep. No. SCMM-WP-MM (1973) [hereinafter cited as HEW Report].

3. U.S. Dep't of Health, Educ. and Welfare, Secretary's Commission on Medical Malpractice 12 (1973) [hereinafter cited as Commission on Malpractice].

4. Regan, *Malpractice, An Occupational Hazard*, The Medico-Legal Reader 235, 236 (S. Polsky ed. 1956).

5. Brooke, *Medical Malpractice: A Socio-Economic Problem From A Doctor's View*, 6 Willamette L.J. 225, 230 (1970).

in his professional relation to his patient, a failure which results in some injury to the patient."[6]

The increase in malpractice litigation is attributed to various causes from diverse sources.[7] Litigation has become a societally acceptable method of venting feelings.[8] It is suggested that the most common elements present in a medical malpractice suit are: "a poor medical result, and a breakdown in the patient-physician relationship."[9]

In some cases of a poor medical result, professional people—doctors, nurses, or lawyers—who make adverse comments may be responsible for their relatives' or friends' suing.[10] In others, the quality of the physician's work product can readily be judged substandard by a layman.

Society forces upon the doctor a difficult role in dealing with patients. Traditionally the doctor is presumed to be "dedicated, gentle and kind, always available, possessing endless charity, inexhaustibly patient, and everlastingly resourceful . . . ."[11] Problems arise when the physician fails to meet these expectations and communications with the patient break down. "[T]he average patient will not happily tolerate, in fact he will not endure, haughty, supercilious treatment, overcharges or suits for fees in cases where results are unsatisfactory, without seeking compensation to soothe his sensibilities and damages for injuries allegedly sustained."[12] The patient may have been kept waiting or may have been affronted by office personnel.[13] The doctor's bill (which might be a shock and surprise), pressure tactics or a suit to collect payment may anger the patient to the point of malpractice action.[14] It has been postulated that the status of the patient may affect the potentiality of a malpractice suit. Studies have shown that the hospitalized patient who functions in a world "where even the smallest details of living-eating, eliminating, and physical position" are controlled and who undergoes a deindividualization that results in an intensification of any dissatisfaction, real or imaginary, is more likely to sue.[15]

However, "patients who have a friendly feeling for the physician and who believe that everything possible has been done for them are not likely to sue for malpractice even in bad-result cases."[16] Establishment of a warm relation-

6. L. Regan, Doctor, Patient and the Law 17 (3d ed. 1956).

7. *See generally* Note, *Malicious Prosecution: An Effective Attack On Spurious Medical Malpractice Claims?*, 26 Case W. Res. L. Rev. 653 (1976) [hereinafter cited as Case W. Res. L. Rev. Note].

8. Address by W. Beckman, Malpractice Litigation, Overview: Is There a Double Standard, National Medicolegal Symposium, in Las Vegas (Mar. 14-16, 1975).

9. Frankel, *Medico-Legal Communication*, 6 Willamette L.J. 193, 202 (1970).

10. Regan, *supra* note 4, at 238.

11. *Id.* at 236.

12. *Id.* at 238.

13. *Id.*

14. *Id.*

15. Bernzweig, *Legal Aspects of Public Health Service Medical Care*, 42 U.S. Pub. Health Service, Pub. No. 1468.

16. Regan, *supra* note 4, at 239.

ship based on a sincere and intelligent interest in the patient's welfare, characterized by "fair dealing, diligent attentiveness, and reasonable and honest disclosure," has been found to yield positive results.[17]

III. Effects of the Malpractice Action

One outgrowth of malpractice litigation is the practice of defensive medicine, which has been defined as "the alternation of modes of medical practice, induced by the threat of liability, for the principle purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted."[18] Negative defensive medicine results "when a physician does not perform a procedure or conduct a test because of the physician's fear of a later malpractice suit, even though the patient is likely to benefit from the test or procedure in question."[19] The consequence of positive defensive medicine is "the conducting of a test or performance of a diagnostic or therapeutic procedure which is not medically justified but is carried out primarily (if not solely) to prevent or defend against the threat of medical-legal liability."[20]

It is argued that the end product of defensive medicine is a misallocation of medical resources.[21] While positive defensive medicine may have a favorable impact on the treatment of the individual patient, it reduces the potential amount of health care available to society as a whole.[22]

Manifestations of this phenomenon are seen in the doctor's ordering hospitalization for a period of time in excess of that medically necessary and in this way compounding what is in some areas a shortage of needed hospital beds.[23] Also, many tests and x-rays are ordered, creating a backlog in the hospital laboratory.[24] Other demands on the health care system take the form of orders for special nurses or for excessive therapy. These excesses coupled with the obvious increase in the cost of malpractice insurance to the doctor combine to raise the cost of medical care to the consumer.

A less patent and measurable effect of malpractice litigation is that even the doctor who has not been sued may be faced with a general loss of confidence in himself as a practitioner, and it is highly probable that the sued physician will have self-doubts.[25] Either the sued or the unsued doctor may develop a distrust of new patients, with an accompanying "corrosive effect upon the psyche" and performance.[26] The medical profession as a whole may

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17. *Id.*
18. Commission on Malpractice, *supra* note 3, at 14. *See also The Medical Malpractice Threat: A Study of Defensive Medicine*, 1971 Duke L.J. 939 [hereinafter cited as Duke L.J. Study]; HEW Report, *supra* note 2.
19. Commission on Malpractice, *supra* note 3, at 14.
20. *Id.*
21. Duke L.J. Study, *supra* note 18, at 943.
22. *Id.* at 949.
23. Brooke, *supra* note 5, at 231.
24. Frankel, *supra* note 9, at 207.
25. *Id.* at 208.
26. Address by Paul Rheingold, The Remedies of the Wrongfully Sued Professional, Na-

be less eager to try new techniques thereby slowing advances on the scientific front.[27] A hesitancy may develop on the part of members of the profession to publicize in the medical journals problems which individual physicians have encountered.[28] This hesitancy may be explained by a fear that, following scrutiny of the issue by other professionals, they may be faced with a lawsuit. Just as the doctor may have subtle symptoms of a lack of self-confidence, his patients may also lose confidence in him and be less likely to follow his orders.[29]

Malpractice litigation is not without redeeming features to the medical profession. Possible benefits are that the doctor is encouraged to keep better records, that continuing medical education is fostered, and that specialists are consulted when difficult procedures are faced.[30]

Assuming, however, that for the physician the meritorious aspects of malpractice suits are outweighed by deleterious effects, it becomes important to the medical profession to decrease this type of litigation. One proposed method is the physician countersuit.

IV. Countersuits

A. *Why Countersue*

The plight of the doctor which leads to a countersuit is well expressed as follows:

> Even when the jury returns a verdict of not guilty, the accused's friends and neighbors do not have positive assurance that he is innocent; neither does his attorney remit his counsel fees; nor does the investigation agency return its fees. The accused is not reimbursed for the time he lost from work and neither is he compensated for any future loss that might occur as a result of the charge.[31]

In *Wolfe v. Arroyo*,[32] the plaintiff physician, who had been sued for malpractice and awarded a take-nothing summary judgment, alleged in the countersuit he subsequently filed that the litigation had left him in need of psychiatric care and that his mental state prevented him from performing his duties as an orthopedic surgeon. He further alleged that his insurance premiums had been increased and that he would receive fewer referrals with future loss of income because of his diminished reputation among his peers.[33] The physician legitimately felt wronged. Yet, determining whether or not such

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tional Medicolegal Symposium, in Las Vegas (Mar. 14-16, 1975) [hereinafter cited as Rheingold Address].

27. Frankel, *supra* note 9, at 208.
28. Commission on Malpractice, *supra* note 3, at 14.
29. Frankel, *supra* note 9, at 207.
30. *Id.*
31. Note, *Malicious Prosecution - The Law in Arkansas*, 22 Ark. L. Rev. 340, 341 (1968).
32. 543 S.W.2d 11 (Ct. App. Tex. 1976).
33. Similar allegations were made by the physician in Lyddon v. Shaw, 56 Ill. App. 3d 815, 372 N.E.2d 685 (1978).

harm has risen to the requisite degree needed to justify providing a legal remedy is difficult. The court hearing the plaintiff's case held he had failed to state a cause of action.

Is it enough of a remedy that the doctor wins or that the patient drops a case? What if a suit is brought for a small or imagined injury? May the sole purpose of the suit be to obtain the doctor's testimony against another rather than to receive payment for damages?[34] Should suits be allowed, on general principle, to create a nuisance, to extract settlements, to prevent a physician from suing on an unpaid bill or otherwise to harass a physician? Is the failure of an attorney and client to make a careful and thorough analysis of the facts and law before bringing a malpractice suit sufficient grounds for instituting a countersuit?[35] These are questions which currently require answers from the courts.

The existence of the wrongful or meritless suit is evidenced by the experience of the Pima County Medical Society and Bar Association of Tucson. Over a twelve-year period this group examined sixty-five cases of alleged malpractice. Of those cases fifty-seven were found to be without merit.[36]

The medical profession itself is beginning to provide an impetus for its members to fight back. State medical societies in California, Michigan, Illinois and Georgia have established legal funds to aid doctors.[37] The American Medical Association's House of Delegates resolved that "appropriate assistance should be given to the physicians who countersue following frivolous malpractice suits."[38]

While it is relatively easy to empathize with the wrongfully sued medical practitioner and to understand why countersuits are contemplated, finding a method of counterattack presents a degree of difficulty.

B. *Types of Countersuit Actions*

1. *Malicious Prosecution*

The most obvious means of attack and the one which seems to appear most often in the case law is an action for malicious prosecution.[39] Although this action was initially a remedy exclusive to unjustifiable criminal prosecutions, it has gradually been extended into the civil area.[40]

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34. Illinois has enacted a rule which allows adding physicians as respondents in discovery rather than as defendants. *See* Civil Practice Act § 8, ILL. ANN. STAT. ch. 110, § 21.1 (Smith-Hurd Supp. 1978).

35. Rheingold Address, *supra* note 26.

36. Brooke, *supra* note 5, at 229.

37. 12 TRIAL 7 (Sept. 1976).

38. *See* 12 TRIAL 44 (Dec. 1976).

39. *See generally* W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 120 (4th ed. 1971).

40. *Id.* Malicious prosecution actions have been allowed following proceedings in lunacy, contempt, bastardy, juvenile delinquency, arrest under civil process, binding over to keep the peace, attachment, garnishment, replevin, search of premises under a warrant, injunctions, proceedings in bankruptcy, dissolution of a partnership and some proceedings before administrative agencies.

Dean Prosser suggests three reasons of "questionable validity" for why malicious prosecution has not been expanded to include the ordinary civil action. First, costs in a civil action are awarded to the successful party.[41] Second, it is desirable to encourage seeking justice through the courts with no undue fear of a threat of retaliatory action. The good citizen who is sued should be willing to bear any burden arising out of the litigation.[42] Third, litigation must cease at some point and a situation where countersuit follows countersuit should not be fostered.[43]

Because of the refusal of some jurisdictions to allow malicious prosecution actions following all civil proceedings, an American and an English rule have developed. The American rule permits an action regardless of whether or not the person or property of the defendant in the original action has been harmed. The English rule prohibits an action unless there has been "an interference with property or some special injury which would not necessarily result in all suits prosecuted for a like cause of action."[44]

A suit for malicious prosecution will lie when a prior proceeding,[45] terminated in the defendant's favor, was instituted without probable cause and with malice and resulted in actual damages exceeding recoverable costs.[46]

The first element required in a malicious prosecution action, termination in defendant's favor, has presented problems.[47] The termination rule is designed to prevent the expansion of litigation, the rendering of inconsistent judgments and the creation of evidentiary problems raised by the lack of a record from the original proceeding.[48] Termination may mean adjudication on

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41. *Id.* While Prosser believes this may be justification in England where attorney's fees are awarded, in the United States a different situation exists as the real costs of litigation are not covered by amounts set by statute and attorney's fees are disallowed.

42. *Id. See* Smith, *Medical Malpractice: The Countersuit Fad*, 12 TRIAL 44, 45 (Dec. 1976).

43. PROSSER, *supra* note 39, § 120. *See* Hopke v. O'Byrne, 148 So. 2d 755 (Fla. Dist. Ct. App. 1963). *But see* PROSSER, *supra* note 39, at § 120. Prosser sees this fear as counterbalanced by the burden placed on the plaintiff in a malicious prosecution action to prove lack of probable cause and improper purpose.

44. Justice Linde, writing for the Oregon Supreme Court in O'Toole v. Franklin, 279 Or. 513, 569 P.2d 561 (1977), lists these jurisdictions as following the English rule: District of Columbia, Georgia, Illinois, Iowa, Kentucky, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Washington and Wisconsin. Jurisdictions which do not follow the English rule are: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Indiana, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Vermont and West Virginia.

45. It appears that this proceeding should be judicial in nature. In Kauffman v. A.H. Robins Co., 223 Tenn. 515, 448 S.W.2d 400 (1969), the actions of the board of pharmacy, an administrative agency, were held to be judicial, thus allowing a malicious prosecution proceeding.

46. *See generally*, PROSSER, *supra* note 39, § 120; Note, *Physician Countersuits: Malicious Prosecution, Defamation and Abuse of Process As Remedies For Meritless Medical Malpractice Suits*, 45 U. CINN. L. REV. 604 (1976) [hereinafter cited as U. CINN. Note]. For a review of Iowa case law, see Bickel v. Mackie, 447 F. Supp. 1376, 1379 (N.D. Iowa 1978).

47. *See* Hoppenstein v. Zemek, ___ App. Div. 2d ___, 403 N.Y.S.2d 542.

48. CASE W. RES. L. REV. Note, *supra* note 7, at 663. *See* Babb v. Superior Court, 3 Cal. 3d. 841, 479 P.2d 379, 92 Cal. Rptr. 179 (1971). In Feldhusen v. Oudenhover, No. 64-233 (Wis.

the merits.[49] Abandonment of the cause[50] or summary judgment[51] also may be sufficient to meet the termination requirement. Compromise or settlement will not provide adequate support for the action.[52]

It can be argued that handling the malicious prosecution action with the original action for malpractice would promote judicial economy as the underlying transaction, the pretrial investigation and much of the testimony would be the same. If at the end of the malpractice trial a cause of action for malicious prosecution became appropriate because of termination of the suit in the original defendant's favor, the same jury could be retained and the action could progress.[53] This was the approach attempted by the Illinois Circuit Court of Cook County in *Berlin v. Nathan.*[54] There the doctor who was sued filed a countersuit against his patient and his patient's spouse and attorneys. The suits were slated to be tried together; however, the malpractice action was withdrawn prior to trial and the countersuit proceeded.

The second element to be proved is that the suit was instituted without probable cause. At least one court has found that probable cause depends on the honest belief of the party bringing the suit, rather than on the actual merit of the case.[55] Dean Prosser suggests the general rule that the termination of a civil case in the defendant's favor is no evidence of lack of probable cause as, unlike the criminal action, no preliminary determination of the sufficiency of the evidence is required to justify the suit.[56] On the other hand, recovery by the original plaintiff "usually is regarded as conclusive evidence of the existence of probable cause even though [the judgment] is subsequently reversed, unless it can be shown to have been obtained by fraud or other imposition upon the court."[57]

The advice of an attorney that a claim has a "reasonable chance" to be found valid is evidence, although not conclusive, of the existence of probable cause.[58] An example of the advice of an attorney establishing probable cause is found in *Carroll v. Kalar.*[59] Kalar, by his attorney, had filed a malpractice

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Cir. Ct., July 20, 1977), the court noted that the favorable termination rule was a device to prevent the filing of malicious prosecution counterclaims as "dilatory" or "harassing" techniques. The reluctance of courts to waive this rule is found in Gasis v. Schwartz, 80 Mich. App. 600, 264 N.W.2d 76 (1978). In that case while a malpractice lawsuit was pending, the doctor filed a malicious prosecution action. The court stood by the requirement of a favorable termination in the original suit.

49. Case W. Res. L. Rev. Note, *supra* note 7, at 662.

50. Sazdoff v. Bourgeois, 301 So. 2d 423 (La. Ct. App. 1974).

51. Carroll v. Kalar, 112 Ariz. 595, 545 P.2d 411 (1976).

52. Prosser, *supra* note 39, § 120.

53. Case W. Res. L. Rev. Note, *supra* note 7, at 663-64.

54. No. 75-M2-542 (June 1, 1976).

55. In Ammerman v. Newman, No. 11181 (D.C. App. Mar. 17, 1978), the doctor's informing the patient of risks and another physician's saying that no malpractice had been committed did not establish lack of probable cause as the evidence indicated less than an informed decision.

56. Prosser, *supra* note 39, § 120. *See* Cassidy v. Cain, 145 Ind. App. 581, 251 N.E.2d 852 (1969).

57. Prosser, *supra* note 39, § 120.

58. 63 Ky. L.J. 237, 240-41 (1974-75).

59. 112 Ariz. 595, 545 P.2d 411 (1976).

suit against Dr. Carroll. Prior to filing the action Kalar's attorney had consulted an attorney-physician concerning the merits of the case.

Before an attorney's advice constitutes probable cause, the lawyer must have full, good-faith disclosure of actual facts from the client without any misrepresentation.[60] An attorney's advice based on information supplied by a client acting in bad faith, "either through a misfeasance in the failure to relate all relevant facts, a malfeasance in the recitation of false information, or a recitation of a claim in which he does not, in good faith, believe . . . ," will not sustain the element of probable cause.[61]

It may well be that there are very few malpractice suits initiated without probable cause as it would seem unreasonable for any attorney to invest the time and the money essential for complex malpractice litigation unless there were reason for him to think the client would win.[62] In fact, the American Bar Association Code of Professional Responsibility says an attorney should refuse to accept a client who wishes to use legal services to harass or maliciously injure.[63] Because the defense of good faith reliance on the advice of counsel may be available to the patient, it would seem to be wise litigation practice for the physician to countersue both the patient and the patient's counsel.[64]

The third necessary element is malice which "*may* consist of a primary motive of ill will, or a lack of belief in any possible success of the action."[65] Improper purpose may be inferred from lack of probable cause.[66]

In *Spencer v. Burglass*,[67] the Louisiana Court of Appeals posed the question of whether or not the failure to get "competent medical advice" constituted malice. The court speculated:

> [A]n affirmative answer to this query would mean that before the attorney brings a malpractice case to trial he must find a medical person who supports the attorney's theory or that of his client, who is willing to testify favorably and who is "competent" by someone's (plaintiff's?) standards. If he finds no such person but he nevertheless, places whatever evidence he can before the court perhaps relying on circumstantial evidence, reasonable inferences and common sense and perhaps realizing that he will probably lose, he runs the risk of having his conduct branded as malicious. When the bald allegation in question is considered in this light it can hardly be construed as one alleging malice.[68]

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60. 63 Ky. L.J. 237, 246 (1974-75). *See also* Sazdoff v. Bourgeois, 301 So. 2d 423, 426 (La. Ct. App. 1974).

61. Case W. Res. L. Rev. Note, *supra* note 7, at 667.

62. Werchick, *Medical Malpractice Suits and Countersuits For Malicious Prosecution*, 15 Cal. Trial Law. J. 181, 184 (1976). *See also* Wills, *Assault With A Deadly Lawsuit: A Wrong In Search Of A Remedy*, 51 L.A.B.J. 499, 501 (1976).

63. ABA Canons Of Professional Ethics DR2-109 (1976). *See also* ethical canon 7-10, which assigns an obligation "to treat with consideration all persons involved in the legal process and to avoid the infliction of needless harm," and disciplinary rule 7-102(A)(1)(2).

64. Case W. Res. L. Rev. Note, *supra* note 7, at 681.

65. Prosser, *supra* note 39, § 120.

66. *Id. See also* Lyddon v. Shaw, 56 Ill. App. 3d 815, 372 N.E.2d 685 (1978).

67. 337 So. 2d 596 (La. Ct. App. 1976).

68. *Id.* at 600. The court also stated that failure to interview witnesses was also not malice. *Id.* at 599.

The fourth and final element to be proved is actual damages exceeding recoverable costs in the original action. Once these damages are shown, Dean Prosser lists these possible bases for recovery: "harm to credit or reputation, expenses incurred in defending the suit, resulting financial loss or injury to business, or even mental suffering of a kind normally to be expected to follow from the action."[69] Making a showing of special damages as required by the English rule becomes a particular problem.[70] The jurisdictions holding to the special injury requirement appear to do so under a rationale expressed by the Illinois Supreme Court in *Smith v. Michigan Buggy Co.*[71]

> Those who favor this species of action, also claim that, if the courts refuse to allow such actions to be maintained, litigation will be encouraged, and causeless and unfounded civil suits will be apt to be brought. On the contrary, the danger is that litigation will be promoted and encouraged by permitting such suits as the present action to be brought. This is so, because the conclusion of one suit would be but the beginning of another. A defendant, who had secured a favorable result in the suit against him, would be tempted to bring another suit . . . . Litigation would thus become interminable.

As a general rule, the small number of reported physician countersuits for malicious prosecution leave the doctor uncompensated. One writer has suggested this cause of action would be a more effective weapon for the physician if greater liberality in pleading were allowed, the English rule necessitating arrest, seizure of property or special injury were abrogated and proof requirements were loosened. Practically, this could be accomplished by allowing counterclaims to be filed during the malpractice proceeding, by using a probable cause standard which imposes a duty on the attorney to investigate with greater care and by defining malice as it was defined in the California case of *Norton v. Hines*[72] as "complete disregard for the rights of a prospective defendant."[73]

2. *Abuse of Process*

A second possible physician counterattack is through an abuse of process action. An abuse of process suit will lie when "legal procedure has been set

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69. PROSSER, *supra* note 39, at § 120.

70. In Brody v. Ruby, 267 N.W.2d 902, 905 (Iowa 1978), the Iowa Supreme Court found no persuasive reason for abolishing its rule that a cause of action for malicious prosecution will not lie unless an arrest, seizure of property or a "special injury" has occurred. Dr. Brody alleged $250,000 in actual damages and $250,000 in exemplary damages based upon his costs in defending the action, mental and physical anguish and damage to his professional and community reputation. The court found the doctor unable to show a loss of practice or diminished income and thus granted summary judgment for defendants on the malicious prosecution count. *See also* Pantone v. Demos, 59 Ill. App. 3d 328, 375 N.E.2d 480 (1978); Lyddon v. Shaw, 56 Ill. App. 3d 815, ____, 372 N.E.2d 685, 689 (1978).

71. 175 Ill. 619, 629-30, 51 N.E. 569, 572 (1898).

72. 49 Cal. App. 3d 917, 123 Cal. Rptr. 237 (1975).

73. 49 Cal. App. 3d at ____, 123 Cal. Rptr. at 241; *see* CASE W. RES. L. REV. Note, *supra* note 7, at 685.

in motion in proper form, with probable cause, and even with ultimate success, but nevertheless has been perverted to accomplish an ulterior purpose for which it was not designed."[74] Although there are areas in which abuse of process and malicious prosecution overlap, there are also distinctions. In abuse of process actions, there is no need to prove termination in the defendant's favor or lack of probable cause. It can be argued that malice is required, but it is not the ill will or absence of possible success required in malicious prosecution suits. Rather, it is an ulterior purpose coupled with a "wilful act in the use of process not proper in the regular conduct of the proceeding."[75] While the elements of an abuse of process action are somewhat different from those for malicious prosecution, the probability of the practitioner obtaining relief remains relatively low.[76]

3. *Prima Facie Tort*

The appellate division of the New York Supreme Court in *Drago v. Buonagurio*[77] examined a physician's complaint to see if an action for malicious prosecution, abuse of process or negligence on the part of the patient's attorney would lie. The doctor, who had never directly or indirectly treated the patient in his final illness, was sued in the original action by the administratrix of the deceased patient's estate. It was alleged that naming the doctor was a discovery device to discern where responsibility for the death might lie. Although the court was unable to fit the doctor's suit against the administratrix and her attorney into either an action for malicious prosecution, abuse of process or negligence, it found the doctor had alleged a cause of action. While the opinion of the court said labeling the action was "immaterial" and "unimportant," it appeared to be proceeding under a theory first propounded by Justice Holmes more then seventy years ago in *Aikens v. Wisconsin*:[78] prima facie tort.[79] The court cautioned that it was not creating a new cause of action to be used by physicians escaping liability in malpractice actions, and in a subsequent decision[80] the second department appears to verify the narrowness of the *Drago* decision.

A contrary result was reached by the Illinois Appellate Court when faced

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74. PROSSER, *supra* note 39, at § 121. For a review of Iowa's position on abuse of process, see Bickel v. Mackie, 447 F. Supp. 1376, 1382 (N.D. Iowa 1978).

75. PROSSER, *supra* note 39, at § 121.

76. *See* Brody v. Ruby, 267 N.W.2d 902 (Iowa 1978); Hoppenstein v. Zemek, ___ App. Div. 2d ___, 403 N.Y.S.2d 542 (1978).

77. 61 App. Div. 2d 282, 402 N.Y.S.2d 250 (1978).

78. 195 U.S. 194 (1904).

79. *See* 61 App. Div. 2d at ___, 402 N.Y.S.2d at 252.

80. Hoppenstein v. Zemek, ___ App. Div. 2d ___, 403 N.Y.S.2d 542 (1978). In a footnote the *Hoppenstein* court pointed to the unique facts in *Drago*, noting at 544 that:

> There the plaintiff doctor alleged that he, in fact, had no association with the patient, either directly or indirectly, during the illness allegedly causing his death. Under those circumstances, the plaintiff could not possibly have been guilty of malpractice. Here, the plaintiff doctor concededly did have some involvement in the treatment of the decedent.

with a unique contention in *Pantone v. Demos.*[81] In *Pantone,* the plaintiff doctors alleged that the state constitution[82] guaranteed them a remedy for the wrongful acts committed against them through the filing of a malpractice action. The court, applying a prior decision by the Illinois Supreme Court,[83] found no mandate in the Illinois constitution for creating a new remedy.

4. *Defamation*

A fourth method of counterattack is a defamation action which might take the form of either libel or slander. The doctor bringing a defamation suit could allege damage to his good name or to his reputation. The defamatory matter must be published to a third person, must be understood both as referring to plaintiff and as being defamatory to him and must cause damages.[83] "[I]t has frequently been held actionable to state of a physician that he is a quack, is incompetent, committed malpractice, charged an exorbitant fee, lacked the requisite professional morality or even that he was drunk when he treated a patient."[84]

The patient defending a defamation suit has a number of defenses available to him. Among them are consent, truth, or privilege. Absolute privilege exists for legislative, executive and judicial proceedings. Because of judicial privilege which has also been extended to other aspects of litigation, false statements made in pleadings are not actionable.[85] Under the English rule, any statement arising out of and reasonably related to the judicial proceeding is privileged.[86] The rule followed in most American courts does not allow judicial privilege to such an extent. Rather, they have adopted a good faith standard, which requires that a statement have a reasonable relationship or in some way be pertinent to some issue in the case.[87] Statements to the press concerning a malpractice suit are not absolutely privileged.[88]

In *Jankelson v. Cisel,*[89] a dentist who countersued his patient for libelous statements made to the dental society and to other dentists regarding allegedly improper treatment was awarded a $12,000 verdict and an injunction prohibiting further statements. A contrary result was reached in *Foster v. McClain,*[90] where the appeals court reversed a $33,000 jury award to the physician who alleged that his patient's attorneys had made a malicious statement about him with wanton disregard for the truth. The existence of

81. 59 Ill. App. 3d 328, 375 N.E.2d 480 (1978). *See also* Lyddon v. Shaw, 56 Ill. App. 3d 815, 372 N.E.2d 685 (1978).

82. The Illinois Constitution provides: "Every person shall find a certain remedy in the laws for all injuries and wrongs which he receives to his person, privacy, property or reputation. He shall obtain justice by law, freely, completely, and promptly." ILL. CONST. art. I, § 12.

83. *See generally* PROSSER, *supra* note 39, at §§ 111-16.

84. Rheingold Address, *supra* note 26.

85. *See generally* RESTATEMENT SECOND OF TORTS § 586 (1977).

86. PROSSER, *supra* note 39, at § 114.

87. *Id.*

88. *Id.*

89. 3 Wash. App. 139, 473 P.2d 202 (1970).

90. 251 So. 2d 179 (La. Ct. App. 1971).

absolute judicial privilege and of various qualified privileges makes any kind of palliation following a medical malpractice action difficult for the sued physician to achieve.

5. *Barratry*

In some jurisdictions an action for barratry might be filed. This tactic was tried in *Lyddon v. Shaw*.[91] The Illinois Appellate Court looked at the language of the barratry statute[92] and decided that multiple acts of a barratrous nature were necessary under the statute as they had been at common law; therefore, the filing of an allegedly baseless medical malpractice suit did not constitute barratry.

6. *Third Party Attorney Negligence*

The remedies discussed so far have involved physician countersuits against the patient in which the patient's attorney might also be joined. Several recent cases have alleged a cause of action against the patient's attorney for breaching a duty to the physician not to file a malpractice suit which he knew or should have known could not be successful. The courts in examining the liability of the patient's lawyer to the doctor sued for malpractice have looked to privity requirements. Thus the attorney is held liable only to those persons who are in privity[93] with him, who stand to benefit from the legal services[94] or who could foreseeably be injured.[95]

The United States District Court for the Northern District of Iowa in *Bickel v. Mackie*[96] was given the opportunity to decide how the Iowa Supreme Court would handle such a case. The opinion noted plaintiff's correct citation of *Friese v. Lemmon*[97] "for the proposition that a professional can be held liable by third parties injured as a result of the professional's negligence,"[98] but then factually distinguished the case and finally held that "[n]egligence is an improper standard upon which to base liability of an attorney to an adverse party."[99]

Two months after the decision in *Bickel*, the Iowa Supreme Court itself

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91. 56 Ill. App. 3d 815, 372 N.E.2d 685 (1978).

92. The Illinois statute provides:

> Barratry-Violations § 26. If any person shall wickedly and willfully excite and stir up any suits or quarrels between the people of this state, either at law or otherwise, with a view to promote strife and contention, he shall be deemed guilty of the petty offense of common barratry; and if he be an attorney or counselor at law, he shall be suspended from the practice of his profession for any time not exceeding six months.

ILL. REV. STAT. ch. 13, § 21 (1975).

93. *See* Feldhusen v. Oudenhoven, No. 64-233 (Wis. Cir. Ct., July 20, 1977).

94. *Id.*

95. *See* Norton v. Hines, 49 Cal. App. 3d 917, 123 Cal. Rptr. 237 (1975).

96. 447 F. Supp. 1376 (N.D. Iowa 1978).

97. 210 N.W.2d 576 (Iowa 1973).

98. 447 F. Supp. at 1381.

99. *Id.* at 1382.

explored the liability issue in *Brody v. Ruby*,[100] wherein Dr. Brody alleged his opponent's attorneys were liable to him for failing to adequately investigate the malpractice claim before filing suit.[101] The court cited the general rule that an attorney is liable for professional negligence to a client only, and that to proceed in a legal malpractice action a third party must be the direct and intended beneficiary of the legal services. The court also refused to impose liability to a third party for his alleged noncompliance with the Iowa Code of Professional Responsibility for Lawyers.[102] The opinion explained that a lawyer's obligation to give zealous representation to a client and the adversary nature of the legal profession created the need for preserving the attorney's immunity from suit by a successful adverse litigant.[103]

In spite of the generalized reluctance on the part of the courts to assign an attorney a duty not only to the client, but to potential defendant doctors as well, one physician has been awarded $6,000 punitive and $2,000 compensatory damages in a suit[104] in which he had alleged that his patient's attorneys had violated a "duty to refrain from wilfully and wantonly bringing suit against him and involving him in litigation without having reasonable cause to believe that he had been guilty of malpractice that proximately caused injury . . . ."[105] The facts behind this allegation were that the attorneys had filed suit three days after they received the patient's medical records and failed to contact physicians to verify the charges. Whether this case will stand as an anomaly or will be the harbinger of alleviation for the wrongfully sued professional remains to be seen. In the interim, attorneys handling plaintiffs' cases may be encouraged to conduct extensive and thorough investigations prior to filing malpractice actions.

The probability that any of the causes of action discussed above would provide the wrongfully sued physician relief is slim. It is well to remember that one of the attorney's prime responsibilities is to avoid litigation.[106] There-

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100. 267 N.W.2d 902 (Iowa 1978).

101. Specifically, Brody's allegations were based on IOWA CODE OF PROFESSIONAL RESPONSIBILITY FOR LAWYERS DR6-101(A)(2) (1971), which provides that "[a] lawyer shall not handle a legal matter without preparation adequate in the circumstances," and DR7-102(A)(1), which provides that "[i]n his representation of a client, a lawyer shall not file a suit, assert a position, conduct a defense, delay a trial, or take other action on behalf of his client when he knows or when it is obvious that such action would serve merely to harass or maliciously injure another." *See* Gasis v. Schwartz, 80 Mich. App. 600, 264 N.W.2d 76 (1978); O'Toole v. Franklin, 279 Or. 513, 569 P.2d 561 (1977) (cases alleging failure of patient's attorney to investigate).

102. 267 N.W.2d at 907; *see* Bickel v. Mackie, 447 F. Supp. 1376, 1383 (N.D. Iowa 1978). *See generally* note 101 *supra*.

103. 267 N.W.2d at 907. It should be noted that the court did not discount the possibility of a party who had to defend a groundless suit at some later time pursuing disciplinary proceedings against the opponent's attorney. *Id.* at 908. A similar conclusion was reached by the Illinois Appellate Court in Lyddon v. Shaw, 56 Ill. App. 3d 815, 823, 372 N.E.2d 685, 691 (1978). However, the court also said attorneys could not be expected to be insurers of their client's cases, nor should they be held liable for failing to make a determination which should ultimately be made by a court. *Id.* at ____, 372 N.E.2d at 690.

104. Berlin v. Nathan, No. 75-M2-542 (Ill. Cir. Ct. June 1, 1976).

105. Berlin Complaint, Count I, at para. 14.

106. Rheingold Address, *supra* note 26.

fore, alternatives to further and probably unsuccessful litigation, such as physician countersuits, should be explored.

V. Alternatives to the Countersuit

One legal scholar sees the solution to the problem of the wrongfully sued professional to be first the inhibition of wrongful suits and secondly compensation for the wrongfully sued party.[107] He believes that if a plaintiff knew he would have to pay his doctor's counsel's fees and other costs of litigation if his suit were held frivolous, he would be reluctant to bring a weak suit.

Options for the patient do exist. One possible panacea is the patient grievance mechanism. Under this system investigators would examine claims with the investigation becoming the basis for settlement. The patient grievance mechanism is seen as a means of "(a) alleviating grievances that could lead to malpractice claims; (b) bringing about equitable settlements in the early stages of disputes; and (c) pinpointing within an institution procedures and situations that could lead to malpractice situations."[108]

Screening panels or arbitration boards are also potential cures.[109] Although physicians may be universally practicing preventative medicine, many neglect to develop adequate prophylaxis against unwanted litigation. While countersuits may in rare instances provide relief for the wrongfully sued doctor, the preferred course would be to preclude suits. Steps to be taken by the physician include the following:

- greater attention to the non-medical causes of malpractice actions;[110]
- careful and thorough forewarning of the potential risks to the patient;
- assurance that consent is understandingly and willingly given;[111]
- attention to patient's fears and worries;
- attention to record-keeping and the taking of medical histories;[112]

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107. *Id.*

108. Commission on Malpractice, *supra* note 3, at 84. *See also* Appendix to Report at 758.

109. Commission on Malpractice, *supra* note 3 at 89. *See also* Appendix to Report at 214, 315, 321, and 346.

110. Included here might be such things as advising a patient of a prolonged absence from practice and the provision for substitute medical care or discussion of fees with an eye toward reaching an understanding. Address by Martin, How To Avoid Malpractice Liability, National Medicolegal Symposium, in Las Vegas (Mar. 13-15, 1969) [hereinafter cited as Martin Address]. Another recommmendation is the removal of books and magazines dealing with medical economics from the doctor's waiting room. Shayne, *Meritless Malpractice Cases: A Fragile Dilemma*, 11 Trial 29 (May-June 1975).

111. Shayne, *supra* note 110, at 29. One suggestion is that a patient be given a printed booklet describing the procedure to be followed with a place for a signature at the end.

112. Martin Address, *supra* note 110. Necessary records would consist of:

> (a) records that would be acceptable when offered in court, (b) records that clearly show what was done and when it was done, (c) records which establish that nothing was neglected and that the given carefully met the standard demanded by the law. If any patient discontinues treatment before he should or if he fails to follow instructions, the record should show that fact; a good method is to file a carbon copy of the letter sent the patient advising him against the unwise course.

- elimination of unguarded comments about another physician's work;[113]
- more attention to "patient-physician relationship;"
- better policing by medical associations.[114]

Appropriate supportive conduct on the part of the attorney might encompass:

- where possible, obtaining complete knowledge of *all* facts before a suit is filed;
- consulting freely with physicians on matters of medical propriety;[115]
- refraining from naming as defendants those whose liability is unlikely and more honestly attempting to pinpoint fault;
- carefully treating medical experts, including more thoroughly preparing them as to what to expect in the form and nature of a legal proceeding;
- considering the medical expert's time, leading to a more efficient use of the expert;
- relying more on the self-policing aspects of the medical association, including: recognizing the medical ethics by which the physician is bound and more efficiently using policing entities such as local grievance committees and the like.[116]

The solution to the malpractice dilemma may well lie with the interrelationship of the two professions directly involved. The members of these professions seem intent on casting themselves in adversarial roles, which only serves to compound and to aggravate the malpractice problem. No form of countersuit will be quite as effective or satisfactory a relief as that which might be achieved by cooperation and communication between the physician and the attorney.

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113. Martin Address, *supra* note 109. The physician should also exercise care in avoiding statements which would constitute or could be construed as an admission of fault.

> [A]n 'admission' may be damaging to the defendant physician even though it has been made to a third party . . . [or] before the trial . . . [or] by an agent or employee during the course, and within the scope, of his employment.

Id.

114. Frankel, *supra* note 9, at 222.

115. *See* Eaton, *The Need For Mutual Understanding On The Legal And Medico-Scientific Professions*, 8 MED., SER. AND THE L. 78 (1968).

116. Frankel, *supra* note 9, at 22.