

ARTICLES

NONECONOMIC DAMAGE AWARDS IN VETERINARY MALPRACTICE: USING THE HUMAN MEDICAL EXPERIENCE AS A MODEL TO PREDICT THE EFFECT OF NONECONOMIC DAMAGE AWARDS ON THE PRACTICE OF COMPANION ANIMAL VETERINARY MEDICINE

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Many scholars have argued for and against the recovery of noneconomic damages in cases of veterinary malpractice involving companion animals. However, scholarship has not focused on the results that allowing noneconomic damages may have on the structure of companion animal veterinary practices. This Article uses the human medical field as a predictive model to explore the potential effects of granting noneconomic damages in veterinary malpractice cases.

The author argues that awarding damages substantial enough to encourage increased litigation will result in significant changes in the field of veterinary medicine. Allowing for recovery of noneconomic damages will make veterinary care more expensive and will not significantly deter negligent malpractice. Individuals will pay more for veterinary care or companion animals will receive less care if high noneconomic damage awards become the norm in veterinary malpractice cases. Although these changes will affect all veterinary facilities, ironically, high quality veterinary facilities may be more likely to be sued than their lower quality counterparts. The author concludes by discussing alternatives to malpractice litigation, the human-animal bond, and the possible factors contributing to the high cost of human medicine in the United States.

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I. INTRODUCTION

From Darwin’s tangled bank of unceasing struggle, selfishness, and death, had arisen, incomprehensibly, the thrower who loved not man, but life. It was the subtle cleft in nature before which biological thinking had faltered. We had reached the last shore of an invisible island—yet, strangely, also a shore that the primitives had always known. They had sensed intuitively that man cannot exist spiritually without life, his brother

—Loren Eiseley,
*The Star Thrower*¹

The bond between humans and companion animals has existed since before written history. It has existed since the first wild dog and prehistoric human decided they were both made better off by living

¹ Loren Eiseley, *The Unexpected Universe* 91 (Harcourt, Brace & World, Inc. 1969).

together.² Initially, and for tens of thousands of years thereafter, companion animals were primarily working animals used for protection, vermin control, and hunting.³

Much more recently, at least in the urbanized areas of developed countries, the emphasis has become solely one of companionship for the human. In addition to providing companionship, pets have been shown to provide numerous health benefits for their people, including decreasing stress, lowering blood pressure, and improving cognitive function.⁴ In most cases, dogs and cats are looked on as family members and even as child substitutes.⁵ Thus, dogs have left the yard and field and cats have left the barn, and both now frequently share beds with their humans.

This change in, and development of, the human-animal bond has led to an increased subjective value being placed on some pets by their people. The dog that shares a bed with a human tends to be more highly valued than a dog that sleeps under the porch. Harm that comes to a pet that is considered a part of the family or a child substitute resonates much more loudly in their peoples' minds than harm that comes to a barn cat.

This change in the subjective valuation of some pets by some people, combined with pressure from the animal rights movement and the legal community, has led to great interest in the questions of the legal status of animals and the proper legal remedies for negligent or intentional harm to those animals.⁶ This paper will discuss one small aspect of these questions: What potential effects might the granting of noneconomic damages as a remedy for veterinary medical negligence have on the field of veterinary medicine? Using the experience of the effects of litigation in the human medical field as a model, this paper will attempt to predict what effects similar litigation might have on the field of veterinary medicine.

II. LEGAL THEORIES ALLOWING RECOVERY IN HUMAN AND VETERINARY MALPRACTICE

There are several general legal theories under which one may pursue an action for veterinary malpractice. These include tort theory,

² Robert H. Dunlop & David J. Williams, *Veterinary Medicine: An Illustrated History* 35 (Mosby-Year Book 1996).

³ *Id.*

⁴ Lynn A. Epstein, *Resolving Confusion in Pet Owner Tort Cases: Recognizing Pets' Anthropomorphic Qualities Under a Property Classification*, 26 S. Ill. U. L.J. 31, 35 (2001).

⁵ William C. Root, "Man's Best Friend": Property or Family Member? An Examination of the Legal Classification of Companion Animals and Its Impact on Damages Recoverable for Their Wrongful Death or Injury, 47 Vill. L. Rev. 423, 437 (2002).

⁶ See Epstein, *supra* n. 4, at 31 ("[T]he injury or loss of such an exalted 'family member' may result in dissatisfaction with the measure of damages afforded in the prototypical property damage scenario."); see also Root, *supra* n. 5, at 424 (examining current discussions relating to increasing compensatory damages).

contract theory,⁷ and possibly bailment theory.⁸ As in human medical malpractice cases, veterinary malpractice cases are generally pursued under a tort theory due to the types of damages that can be recovered under that approach.⁹ Legal damages in tort cases can be divided into three general categories: compensation for economic loss, compensation for noneconomic loss, and punitive damages.¹⁰ Economic damages include compensation for such things as lost wages or earning capacity and medical expenses.¹¹ Noneconomic damages include compensation for pain and suffering, loss of companionship, and emotional distress.¹² Punitive damages may be assessed in cases of gross negligence or other extreme breaches of the standard of care.¹³ In the case of litigation and awards for negligent harm to a human being, all three of these types of damages may be of significant financial magnitude.¹⁴ In the case of veterinary malpractice, however, an award for negligent harm to a companion animal rarely generates significant dollar amounts in any of the three categories of damages.¹⁵ This stems from the fact that animals are classified as property under the law.¹⁶

A. Economic Damages

One of the major impediments to recovering economic damages for negligent harm to an animal is the difficulty of accurate valuation of the economic worth of that animal. In human medicine, economic damages include the value of loss of time and loss of earning capacity¹⁷ and medical expenses.¹⁸ Calculations of these sorts of damages are routinely performed in human malpractice cases.¹⁹ Because animals are property, damages that can be recovered for their harm are limited to those legal remedies available to owners for damage to any sort of property.²⁰ Traditionally, the legal remedy for damage to property has

⁷ 90 Am. Jur. Proof of Facts 3d *Actions Involving Injuries to Animals* § 12 (2006).

⁸ See Katie J.L. Scott, Student Author, *Bailment and Veterinary Malpractice: Doctrinal Exclusivity, or Not?*, 55 *Hastings L.J.* 1009 (2004) (arguing that pet owners should be able to recover for veterinary negligence under the bailment doctrine).

⁹ 61 Am. Jur. 2d *Physicians, Surgeons, and Other Healers* §§ 340–342 (2002); 32 Am. Jur. Proof of Facts 3d *Veterinary Malpractice* § 7 (1995).

¹⁰ Frank A. Sloan & Lindsey M. Chepke, *Medical Malpractice* 108–09 (MIT Press 2008).

¹¹ 61 Am. Jur. 2d *Physicians, Surgeons, and Other Healers* § 341.

¹² *Id.* at §§ 341–342.

¹³ *Id.* at § 344.

¹⁴ See *e.g. id.* at § 343 (showing a jury award of \$600,000 “where the plaintiff no longer was able to enjoy an active social and athletic life-style and experienced personal emotional trauma”).

¹⁵ Root, *supra* n. 5, at 423–24.

¹⁶ *Id.* at 423.

¹⁷ 22 Am. Jur. 2d *Damages* § 123 (2003).

¹⁸ *Id.* at § 122.

¹⁹ Victor E. Schwartz & Emily J. Laird, *Non-Economic Damages in Pet Litigation: The Serious Need to Preserve a Rational Rule*, 33 *Pepp. L. Rev.* 227, 230 (2006).

²⁰ *Id.* at 235.

been the payment of the fair market value of the property.²¹ Fair market value is “defined as what the property in question could probably have been sold for on the open market, in the ordinary course of voluntary sale by a leisurely seller to a willing buyer.”²² A fair market valuation would consider, for example, the type, breed, and characteristics of the pet, in addition to any special training the pet had undergone.²³ Thus, recovery for a pet that was killed would be the amount required to purchase a similar pet at the time of the pet’s death.²⁴ Many courts have struggled with this fact. The Wisconsin Supreme Court in one case stated, “We are uncomfortable with the law’s cold characterization of a dog . . . as mere ‘property.’ Labeling a dog . . . ‘property’ fails to describe the value human beings place upon the companionship that they enjoy with a dog. A companion dog is not a fungible item”²⁵ Because of this, in some cases, sympathetic courts have looked to or created other valuation approaches in assessing damages for the harm to a pet. “This patchwork approach to pet valuation has led to misapplications of damage award theories, lack of reconcilable precedent and confusion among the practicing bar.”²⁶ In some cases, courts have held that reasonable veterinary expenses could be recovered even in cases where those expenses far outweighed the fair market value of the pet. For example, a court in Kansas ruled that

the award of the amount . . . spent on veterinary bills is in accord with the very purpose of the law of damages—to make [plaintiff] whole and return her to the position she was in prior to [defendant’s] tortious conduct. It can hardly be said that a lesser award—for example, [the dog’s] original purchase price of \$175 depreciated over 13 years—would ‘make good the injury done.’²⁷

Another valuation approach is calculation of the pet’s value to the owner.²⁸ In this case, a court might take into account loss of companionship,²⁹ the unique value of the particular pet to the owner,³⁰ the amount spent on veterinary care for the pet,³¹ and, rarely, sentimental value.³² However, whatever approach is used to value a pet for the

²¹ Root, *supra* n. 5, at 423–24.

²² Schwartz & Laird, *supra* n. 19, at 232.

²³ Epstein, *supra* n. 4, at 37.

²⁴ Root, *supra* n. 5, at 424.

²⁵ *Rabideau v. City of Racine*, 627 N.W.2d 795, 798 (Wis. 2001).

²⁶ Epstein, *supra* n. 4, at 32.

²⁷ *Burgess v. Shampooch Pet Indus., Inc.*, 131 P.3d 1248, 1253 (Kan. App. 2006).

²⁸ *Brousseau v. Rosenthal*, 443 N.Y.S.2d 285, 286 (N.Y. Civ. Ct. 1980).

²⁹ *Id.*

³⁰ *McDonald v. Ohio St. U. Veterinary Hosp.*, 644 N.E.2d 750, 752 (Ohio Ct. Cl. 1994).

³¹ *Burgess*, 131 P.3d at 1253.

³² *Jankoski v. Preiser Animal Hosp.*, 510 N.E.2d 1084, 1087 (Ill. App. 1987).

purposes of awarding economic damages, the award is typically nominal at best.³³

In order to attempt to bypass the common law approach to classifying animals as property, alternative legal classifications for animals have been proposed. These include such classifications as sentient property,³⁴ companion animal property,³⁵ companion constitutive chattel,³⁶ and providing animals with “equitable self-ownership.”³⁷ One of the theories behind changing the legal status of animals is that it will allow courts to ignore the common law precedent regarding valuation of animals as property.³⁸ Another is that it will allow courts to increase awards in animal cases without worrying that they will be opening the floodgates to larger awards in non-animal harm-to-property cases.³⁹ To date, however, there appear to be no published cases using any of the aforementioned alternative legal classifications of animals.

B. Noneconomic Damages

Because of the lack of significant available economic damages in most cases of harm to animals, there is much interest in the potential of recovering noneconomic damages. In human medicine, noneconomic damages include compensation for pain and suffering, loss of companionship, and emotional distress.⁴⁰ At common law in virtually all jurisdictions, recovery cannot be made for emotional pain and suffering caused by damage to property.⁴¹ Thus, courts that follow the common law precept that animals are legally classified as personal property do not allow pain and suffering claims for the injury or death of a pet animal.⁴² Additionally, since property cannot (legally) experience pain and suffering, no claim can be made on behalf of the pet animal.⁴³

Christopher Green states that, “loss of companionship is the most uniform, consistent, and administrable of all the existing causes of ac-

³³ Elaine T. Byszewski, *Valuing Companion Animals in Wrongful Death Cases: A Survey of Current Court and Legislative Action and a Suggestion for Valuing Pecuniary Loss of Companionship*, 9 *Animal L.* 215, 240 (2003).

³⁴ Susan J. Hankin, *Not a Living Room Sofa: Changing the Legal Status of Companion Animals*, 4 *Rutgers J.L. & Pub. Policy* 314, 385 (Winter 2007).

³⁵ *Id.* at 379.

³⁶ Mary Margaret McEachern Nunalee & G. Robert Weedon, *Modern Trends in Veterinary Malpractice: How Our Evolving Attitudes Toward Non-Human Animals Will Change Veterinary Medicine*, 10 *Animal L.* 125, 130 (2004).

³⁷ David Favre, *Equitable Self-Ownership for Animals*, 50 *Duke L.J.* 473, 475 (2000).

³⁸ Hankin, *supra* n. 34, at 337–42.

³⁹ Casey Chapman, *Not Your Coffee Table: An Evaluation of Companion Animals as Personal Property*, 38 *Cap. U. L. Rev.* 187, 196–97 (2009).

⁴⁰ Schwartz & Laird, *supra* n. 19, at 230.

⁴¹ *Id.* at 235–37.

⁴² *Id.*

⁴³ Ani B. Satz, *Animals as Vulnerable Subjects: Beyond Interest-Convergence, Hierarchy, and Property*, 16 *Animal L.* 65, 82 (2009).

tion for loss of a companion animal due to veterinary negligence.”⁴⁴ However, courts continue to reject this approach,⁴⁵ typically using a public policy argument that there is no “compelling reason why, as a matter of public policy, the law should offer broader compensation for the loss of a pet than would be available for the loss of a friend [or] relative.”⁴⁶

Claims of negligent infliction of emotional distress for harm to a pet are rarely successful.⁴⁷ One commentator states that, “[to] recover in most jurisdictions, claimants must prove they were near the scene of the accident, they experienced trauma directly resulting from the witness of the accident, and they were closely related to the accident victims.”⁴⁸ Even assuming that a plaintiff could convince a court that they were “closely related” to his or her pet, veterinary malpractice is rarely observed by pet owners and thus the first two prongs of the analysis are rarely met.

Claims of intentional infliction of emotional distress are occasionally more successful in cases of harm to pets.⁴⁹ However, the claim of intentional infliction of emotional distress is rarely, if ever, successful in the veterinary malpractice context since Section 46 of the Restatement (Second) of Torts states that the actions of the veterinarian must be directed towards the owner of the pet rather than the pet itself.⁵⁰ Because of this, in a Pennsylvania case, the court stated that it would permit no claim for intentional infliction of emotional distress for a veterinarian’s behavior toward a dog under any circumstance.⁵¹

Because the common law is so inhospitable to noneconomic damage claims for the injury or death of a pet, proponents of allowing these types of claims have resorted to the legislative process.⁵² Many statutes have been proposed in the legislatures of various states, but few have become law. Tennessee and Illinois are examples of states where such laws have been enacted. Tennessee allows up to \$5,000 in noneconomic damages for harm to a cat or dog, “limited to compensa-

⁴⁴ Christopher Green, *The Future of Veterinary Malpractice Liability in the Care of Companion Animals*, 10 *Animal L.* 163, 241 (2004).

⁴⁵ See e.g. *Goodby v. Vetpharm*, 974 A.2d 1269 (Vt. 2009) (refusing to extend recovery under the Wrongful Death Act to include death of a companion animal); *McMahon v. Craig*, 176 Cal. App. 4th 1502, 1519–20 (2009) (upholding the trial court’s decision to strike claim for loss of companionship because California law does not allow parents to recover for loss of companionship of their children).

⁴⁶ *Goodby*, 974 A.2d at 1274.

⁴⁷ Epstein, *supra* n. 4, at 39–40; but see e.g. *Campbell v. Animal Quarantine Station*, 632 P.2d 1066 (Haw. 1981) (award of \$1,000); *Knowles Animal Hosp., Inc. v. Wills*, 360 So. 2d 37, 38 (Fla. 3d Dist. App. 1978) (award of \$13,000).

⁴⁸ Epstein, *supra* n. 4, at 40.

⁴⁹ See e.g. *La Porte v. Associated Independents, Inc.*, 163 So. 2d 267 (Fla. 1964) (stating that, irrespective of value of animal, malicious destruction of pet provides element of damage for which owner should recover).

⁵⁰ *Restatement (Second) of Torts* § 46 (1965).

⁵¹ *Miller v. Peraino*, 626 A.2d 637, 640 (Pa. Super. 1993).

⁵² Elizabeth L. Settles & Sarah L. Babcock, *Veterinary Legal Issues: 2006 in Review*, 230 *J. Am. Veterinary Med. Assn.* 350, 350 (Feb. 1, 2007).

tion for the loss of the reasonably expected society, companionship, love and affection of the pet.”⁵³ However, the statute specifically exempts veterinarians.⁵⁴ Illinois allows up to \$25,000 in noneconomic damages for harm to a pet animal, but the statute limits recovery to cases where the defendant has committed torture and/or aggravated cruelty.⁵⁵ Statutes that would be routinely applicable to cases of veterinary malpractice have yet to be passed by any state legislature.

C. Punitive Damages

Punitive damages focus on the behavior of the defendant, not the emotional harm to the plaintiff.⁵⁶ Thus, they may be recovered in cases of harm to pet animals.⁵⁷ To determine “the proper punitive damage award, the court will consider the following: (1) degree of malice, (2) amount needed to deter such conduct, (3) wealth of the perpetrator, (4) sentimental value of the animal, and (5) degree of pain and suffering of the pet owner.”⁵⁸ Punitive damages have rarely been assessed in veterinary malpractice, but because they focus on the behavior of the defendant, they are at least theoretically available to plaintiffs even in jurisdictions that treat pet animals strictly as property without any value beyond fair market value.

The lack of significant “economic value” of the vast majority of companion animals, combined with the general lack of availability of noneconomic damages in cases of harm to an animal, has meant that awards in veterinary malpractice cases have tended to have minimal economic impact on companion animal veterinarians or their liability insurers.⁵⁹ In fact, few cases claiming veterinary malpractice are initiated due to the lack of potential monetary recovery to justify the expense of bringing the case.⁶⁰ This lack of malpractice litigation against veterinarians has no doubt had a significant effect on the profession of veterinary medicine, just as the plethora of malpractice litigation in human medicine has had a profound effect on that profession.

III. A BRIEF HISTORY OF HUMAN MEDICAL MALPRACTICE LITIGATION IN THE UNITED STATES

Human medical malpractice suits were uncommon during the early years after the formation of the United States. One historian states that such suits were “virtually nonexistent between 1790 and

⁵³ Tenn. Code Ann. § 44-17-403 (Lexis 2007).

⁵⁴ *Id.*

⁵⁵ 510 Ill. Comp. Stat. Ann. 70/16.3 (West 2004).

⁵⁶ *Levine v. Knowles*, 197 So. 2d 329, 331 (Fla. 3d Dist. App. 1967).

⁵⁷ *Id.* at 332.

⁵⁸ *Root*, *supra* n. 5, at 430.

⁵⁹ *Id.* at 442.

⁶⁰ *Id.* at 444.

1835.”⁶¹ However, as early as the middle of the nineteenth century it was claimed that, “suits for malpractice were so very frequent in the Northern states that many men abandoned the practice of surgery.”⁶² Thereafter, suits for malpractice continued to outstrip population growth for the next 100 years.⁶³

In the nineteenth century, human medicine was “heterogeneously practiced, locally focused, and largely unregulated.”⁶⁴ The seminal case setting out the standards for judging medical liability was *Pike v. Honsinger*.⁶⁵ The court in that case held that

A physician and surgeon, by taking charge of a case, impliedly represents that he possesses, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality where he practices, and which is ordinarily regarded by those conversant with the employment as necessary to qualify him to engage in the business of practicing medicine and surgery. Upon consenting to treat a patient, it becomes his duty to use reasonable care and diligence in the exercise of his skill and the application of his learning to accomplish the purpose for which he was employed. He is under the further obligation to use his best judgment in exercising his skill and applying his knowledge. The law holds him liable for an injury to his patient resulting from want of the requisite knowledge and skill, or the omission to exercise reasonable care, or the failure to use his best judgment.⁶⁶

The standards set out in this case, with the exception of the “locality rule,” have to a great extent remained unchanged.⁶⁷ Due to improvements in education, travel, and communications, many courts have now abandoned the “locality rule” in favor of a national standard.⁶⁸ The new rule is that “a physician is under a duty to use that degree of care and skill which is expected of a reasonably competent practitioner in the same class to which he belongs, acting in the same or similar circumstances.”⁶⁹

Following the decision in *Pike v. Honsinger*, there was a “slow, but steady, rise of suits during the first three decades of the [twentieth] century.”⁷⁰ The increase in suits led inevitably to the rise of malpractice insurance policies.⁷¹ The New York State Medical Society became

⁶¹ Kenneth Allen De Ville, *Medical Malpractice in Nineteenth-Century America: Origins and Legacy* 25 (N.Y.U. Press 1990).

⁶² *Id.*

⁶³ *Id.* at 3.

⁶⁴ Neal C. Hogan, *Unhealed Wounds: Medical Malpractice in the Twentieth Century* 1 (LFB Scholarly Publ., LLC 2003).

⁶⁵ *Id.*

⁶⁶ *Pike v. Honsinger*, 49 N.E. 760, 762 (N.Y. 1898).

⁶⁷ See e.g. 61 Am. Jur. 2d *Physicians, Surgeons, and Other Healers* §§ 188–189 (laying out the physician’s standard of care).

⁶⁸ James O. Pearson, Jr., *Modern Status of “Locality Rule” in Malpractice Action Against Physician Who is Not a Specialist*, 99 A.L.R.3d 1133, 1139 (1980).

⁶⁹ *Id.*

⁷⁰ Hogan, *supra* n. 64, at 33.

⁷¹ *Id.* at 34.

the first such society to initiate a group malpractice insurance policy for its members in 1921.⁷² Following the introduction of malpractice insurance, the number and cost of claims increased markedly.⁷³ One commentator at the time felt that “malpractice insurance was a Pandora’s Box waiting to be opened by plaintiff’s attorneys. Once it was clear that there was money to be had . . . little stood in the way of more suits and larger awards.”⁷⁴

The proliferation of suits went hand in hand with increased national media reporting of medical malpractice. By the late 1950s, articles on malpractice had appeared in *Time*, *U.S. News and World Report*, *Newsweek*, and *The Saturday Evening Post*.⁷⁵ Increased exposure in the media appears to have contributed to an increase in medical malpractice suits during the 1960s and thereafter. By the 1970s, the first of the medical malpractice insurance “crises” had occurred and many called for government action to restrict damage awards and other types of tort reform.⁷⁶ Subsequent malpractice insurance crises as well as huge and much publicized damage awards have led to legislative action of some sort by every state in the union.⁷⁷

By 2003, total annual payments of compensation in human medical malpractice cases was approximately \$5.8 billion.⁷⁸ This has had, as one might expect, profound effects on the practice of human medical care.

IV. EFFECTS OF MALPRACTICE LITIGATION ON HUMAN MEDICINE

The history of human medicine in the twentieth century was one of revolutionary change. As late as the 1930s, medicine was still a “profoundly ignorant occupation.”⁷⁹ The primary duty of the physician was to diagnose and explain; effective treatment was all too frequently unavailable.⁸⁰ The introduction of antibiotics changed all that.⁸¹ Starting in the late 1930s, medical doctors went from ignorance to working miracles.⁸² Naturally, the public’s expectations regarding medical treat-

⁷² *Id.* at 45.

⁷³ *Id.* at 49.

⁷⁴ *Id.* at 50.

⁷⁵ *Id.* at 130–33.

⁷⁶ Catherine M. Sharkey, *Caps and the Construction of Damages in Medical Malpractice Cases*, in *Medical Malpractice and the U.S. Health Care System* 154, 156 (William M. Sage & Rogan Kersh eds., Cambridge U. Press 2006).

⁷⁷ *Id.* at 156–57.

⁷⁸ Michelle M. Mello & David M. Studdert, *The Medical Malpractice System: Structure and Performance*, in *Medical Malpractice and the U.S. Health Care System*, *supra* n. 76, at 11, 13.

⁷⁹ Lewis Thomas, *The Youngest Science: Notes of a Medicine-Watcher* 29 (Viking Press 1983).

⁸⁰ *Id.* at 28.

⁸¹ *Id.* at 35.

⁸² *See e.g. id.* (giving an example of how antibiotics cured a condition within a day or two that was previously fatal).

ment rose dramatically as well, often without an understanding of the attendant risks.⁸³

Due at least in part to increased patient expectations, there was a second driving force for change in the medical profession—the medical malpractice lawsuit. One commentator has stated that “the history of medical malpractice liability is synonymous with the development of medical technology.”⁸⁴ As one might expect, the changes wrought on the medical profession were a mixed bag of the positive and negative. Whether the positives outweigh the negatives is open to interpretation.

A. *Malpractice Insurance*

As briefly noted above, the medical malpractice lawsuit gave rise to medical malpractice insurance. Malpractice insurance in turn provided funds for awards and settlements in malpractice cases.⁸⁵ It also protected physicians from having to pay awards out of their own pockets. Both of these consequences of insurance may be seen as benefits to society. However, there are also costs associated with insurance. The economic costs to physicians and hospitals of malpractice insurance have risen over the years, with the largest increases seen in the last thirty-five years.⁸⁶ In 2000, the average physician paid approximately \$18,000 in malpractice premiums, or about 7.5% of practice expenses.⁸⁷ Moreover, only 40¢ of every dollar spent on malpractice insurance reaches injured patients as compensation.⁸⁸ Perhaps more important than the average cost was the cost to certain medical specialties such as obstetrics and surgery, where premiums rose much more dramatically than those of other specialties.⁸⁹ These relative premium changes may affect the supply of physicians in the area experiencing the premium increase.⁹⁰

Another significant issue with malpractice insurance is the concept of the insurance cycle. Insurance cycles are characterized by periods of “soft” and “hard” market conditions.⁹¹ This results in the decreased availability and increased cost of malpractice insurance during the “hard” cycles. These cycles have contributed to the three malpractice crises that have occurred over the past thirty-five years.⁹²

⁸³ Peter D. Jacobson, *Medical Liability and the Culture of Technology*, in *Medical Malpractice and the U.S. Health Care System*, *supra* n. 76, at 115, 117.

⁸⁴ *Id.* at 115.

⁸⁵ See Hogan, *supra* n. 64, at 45 (providing examples of high awards paid by insurance companies compared to low awards paid by uninsured physicians).

⁸⁶ See Sharkey, *supra* n. 76, at 156 (discussing premiums increasing over time, especially in three crises that have all occurred in the last thirty-five years).

⁸⁷ Sloan & Chepke, *supra* n. 10, at 58–59.

⁸⁸ Mello & Studdert, *supra* n. 78, at 22.

⁸⁹ Sloan & Chepke, *supra* n. 10, at 59.

⁹⁰ *Id.* at 56.

⁹¹ *Id.* at 27.

⁹² Jacobson, *supra* n. 83, at 115.

They also can be at least a temporary disruptive factor in the delivery of health care.⁹³

Finally, another negative effect of insurance is that “the existence of insurance always dampens incentives for taking safety precautions.”⁹⁴ This is especially true in cases where there is no deductible and no experience rating, as is typical with medical malpractice insurance.⁹⁵ This tendency of insurance to reduce the incentive for increasing safety is at odds with the goal of medical malpractice litigation: to increase deterrence against mistakes and negligence in medical practice.⁹⁶ Thus, the existence of insurance—while providing a source of funds for lawsuit awards and protecting the physician from potentially bankrupting liability—introduced other, more negative, factors into the equation as well.

B. *Defensive Medicine*

Perhaps the most well-known and frequently discussed effect of the threat of medical malpractice lawsuits is defensive medicine. There are nearly as many definitions of defensive medicine as there are commentators on the subject. One author defines it as “any waste of resources . . . that results from physicians changing their patterns of medical practice in response to the threat of liability.”⁹⁷ Others state that it “consists of assurance and avoidance behaviors that are induced by apprehension about liability and are of little benefit (compared to their cost), no benefit, or outright harmful.”⁹⁸ Assurance behavior (also known as positive defensive medicine) consists of the overprovision of medical services, while avoidance behavior (also known as negative defensive medicine) consists of the restriction or withdrawal of medical services.⁹⁹ Both of these types of defensive medicine have significant effects on the provision and cost of medical care.

Fifty-nine percent of physicians, in one study, reported “often” ordering more tests than were medically necessary.¹⁰⁰ “Fifty-two percent reported that they often referred patients to other specialists in unnecessary circumstances.”¹⁰¹ One-third of specialist physicians reported often suggesting invasive procedures in clinically inappropriate circumstances.¹⁰² Fifty-seven percent of orthopedic surgeons said they

⁹³ Mello & Studdert, *supra* n. 78, at 27.

⁹⁴ *Id.* at 20.

⁹⁵ *Id.*

⁹⁶ *See id.* at 17 (stating that the goal of all tort law is deterrence).

⁹⁷ Patricia M. Danzon, *The Medical Malpractice System: Facts and Reforms*, in *The Effects of Litigation on Health Care Costs* 28, 29 (Mary Ann Bailly & Warren I. Cikins eds., The Brookings Institution 1985).

⁹⁸ Mello & Studdert, *supra* n. 78, at 23.

⁹⁹ *Id.*

¹⁰⁰ Troyen A. Brennan et al., *Liability, Patient Safety, and Defensive Medicine: What Does the Future Hold?* in *Medical Malpractice and the U.S. Health Care System*, *supra* n.76, at 93, 105.

¹⁰¹ *Id.*

¹⁰² *Id.*

avoided caring for high-risk patients.¹⁰³ Going as far as leaving practice was the response of some of the physicians polled.¹⁰⁴ Thus, at least according to many physicians, widespread and significant defensive medicine is being practiced.

Unfortunately, quantification of the extent and cost of defensive medicine has been “notoriously difficult.”¹⁰⁵ It is relatively easy to state that defensive medicine exceeds “the level of care that is optimal from society’s vantage point [which is the] one at which the marginal social benefit of care equals the marginal social cost of providing it.”¹⁰⁶ However, it is another thing entirely to sort out what actions by a particular physician in a particular situation are “defensive” and what actions are merely providing care that is clinically appropriate but has only a marginal benefit.¹⁰⁷ Additionally, it may be financially beneficial for physicians and hospitals to err on the side of caution when deciding which tests and procedures to order, which confuses the issue even further.¹⁰⁸ One study estimated that the total cost of professional liability is \$13.7 billion per year and that practice changes account for \$10.6 billion of that figure.¹⁰⁹ However, that study has been criticized as exaggerating the cost of defensive medicine.¹¹⁰ Nevertheless, even though quantification is difficult, that does not mean that there are not costs or that the costs are not significant.

The costs of defensive medicine may include economic costs such as costs of the unnecessary tests themselves; economic costs associated with patients being off from work for doctor visits; and direct costs to the patient in terms of deductibles if insured or the full cost if uninsured. Additional costs to the patient include physical pain and discomfort associated with some diagnostic tests and emotional worry associated with waiting for test results. Additionally, the more tests that are performed, the more likely “abnormal” results will be found, leading to yet another round of tests to clarify the results of the first round.¹¹¹ Finally, there is another potential cost to society—that is, defensive medicine may be self reinforcing; the more physicians provide aggressive treatment for low-risk conditions or order unnecessary tests, the higher the probability that those practices will become the

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ Mello & Studdert, *supra* n. 78, at 24.

¹⁰⁶ Sloan & Chepke, *supra* n. 10, at 15.

¹⁰⁷ See Mello & Studdert, *supra* n. 78, at 25 (describing actions that may be classified as defensive as “of little benefit,” “of no benefit,” or “harmful”; those actions that are of little benefit carry a marginal benefit that is arguably too small to justify its expense).

¹⁰⁸ See Brennan et al., *supra* n. 100, at 112 (explaining that defensive medicine may be profitable).

¹⁰⁹ Roger A. Reynolds et al., *The Cost of Medical Professional Liability*, 257 *J. Am. Veterinary Med. Assn.* 2776, 2778 (May 22/29 1987).

¹¹⁰ Kenneth Jost, *Still Warring Over Medical Malpractice: Time for Something Better*, 79 *ABA J.* 68, 71 (May 1993).

¹¹¹ Karen J. Carlson et al., *The New Harvard Guide to Women’s Health* 86 (Harv. U. Press 2004).

legal standard of care.¹¹² Thus, those physicians who are not practicing defensive medicine may be forced into following the lead of their defensive colleagues or leave themselves open to charges of practicing below the standard of care.

C. Doctor-Patient Communication

One of the major effects of malpractice litigation was to change the ways that doctors communicated with their patients. Litigation slowly, and in some cases quickly, eroded the idea that doctors knew better than their patients. The seminal 1905 case of *Mohr v. Williams* brought the legal concept of consent to the practice of medicine.¹¹³ *Mohr* held that

The patient must be the final arbiter as to whether he shall take his chances with the operation, or take his chances of living without it. Such is the natural right of the individual, which the law recognizes as a legal right. Consent, therefore, of an individual, must be either expressly or impliedly given before a surgeon may have the right to operate.¹¹⁴

Informed consent is a somewhat newer concept, requiring that the patient not only consent to a procedure but also understand the risks, benefits, and alternatives to the procedure before consenting.¹¹⁵ Such communication requires the physician to tailor the discussion to a patient's own situation—medical, social, cultural, and educational.¹¹⁶ Being able to effectively communicate important factors for patient consideration so that the patient can truly understand the procedure is extremely important, legally and medically, for both physician and patient.

In addition to the concepts of consent and informed consent, there have been other changes in doctor-patient communication in reaction to malpractice litigation. Studies have shown that having a good relationship with patients and a good bedside manner may be an effective way to avoid being sued for malpractice.¹¹⁷ Similarly, there is evidence that an apology for an unexpected or adverse outcome may be enough to reduce the likelihood of a lawsuit.¹¹⁸ Some defense attorneys, however, advise their physician clients against this tactic.¹¹⁹ In general, patients who felt they were rushed, did not receive explanations, and were ignored by their physicians were more likely to sue than patients

¹¹² David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J. Am. Med. Assn. 2609, 2616 (2005).

¹¹³ *Mohr v. Williams*, 104 N.W. 12, 14–15 (Minn. 1905).

¹¹⁴ *Id.*

¹¹⁵ Roy F. Kaufman & Marjorie O. Thomas, *Lessons Learned Defending Physicians: The Attorney's Perspective*, in *Practicing Medicine in Difficult Times: Protecting Physicians from Malpractice Litigation* 211, 224 (Marjorie O. Thomas et al. eds., Jones & Bartlett Publishers 2009).

¹¹⁶ *Id.* at 225.

¹¹⁷ Sloan & Chepke, *supra* n. 10, at 77.

¹¹⁸ *Id.* at 78.

¹¹⁹ *Id.*

who did not feel that way.¹²⁰ In sum, poor communication is one of the largest factors in changing a “patient to a plaintiff.”¹²¹ Thus, physicians have an incentive to communicate well and thoroughly with their patients.

One unfortunate factor in this discussion is that good bedside manner may be enough to overwhelm poor medical care. Since one of the major rationales for medical malpractice litigation is that it reduces substandard care,¹²² it seems ironic that it is possible to train physicians to have good enough bedside manner to get away with a standard of care that would invite lawsuits for their less affable colleagues.

Undermining this incentive to communication is a tendency for physicians to have a “less personal” relationship with their patients due to liability concerns.¹²³ A smaller but still significant number of physicians felt that liability concerns made them less candid with their patients.¹²⁴ In some cases, “the threat of medical malpractice litigation leads to excessive secrecy about specific medical errors, both out of fear that discussion of medical errors will lead to more lawsuits and that the discussion could be introduced by plaintiffs at trial as evidence of defendant liability.”¹²⁵ Thus, there is a tension between the desire for open doctor-patient communication as a tool to reduce the likelihood of a lawsuit and the fear that something the doctor says will be used in a lawsuit.

Ultimately, good doctor-patient communication is beneficial to both the physician and the patient. To the extent that medical malpractice litigation has encouraged or even mandated communication, it has helped to achieve this goal. To the extent that it has caused doctors to feel less able to talk to their patients, medical malpractice litigation has undermined this goal.

D. Record Keeping

One of the major effects of malpractice suits in the early decades of the twentieth century was the transformation of medical records from an exercise in keeping notes on a patient to a “vital legal record of treatment.”¹²⁶ Medical records, ranging from x-ray studies to notes of discussions with patients, became one of the major ways that physi-

¹²⁰ *Id.* at 77.

¹²¹ Barry F. Schwartz & Geraldine M. Donohue, *Communication Is Crucial*, in *Practicing Medicine in Difficult Times: Protecting Physicians from Malpractice Litigation*, *supra* n. 115, at 47, 69.

¹²² See Sloan & Chepke, *supra* n. 10, at 312 (stating that “injury deterrence is typically listed as the first goal of tort liability”).

¹²³ Mello & Studdert, *supra* n. 78, at 25.

¹²⁴ *Id.*

¹²⁵ Sloan & Chepke, *supra* n. 10, at 313.

¹²⁶ Hogan, *supra* n. 64, at 72.

cians could defend themselves against allegations of malpractice.¹²⁷ Records, which in the past had been somewhat haphazardly kept, were to be accurate, thorough, and complete so that they could be successfully used in the defense of malpractice claims.¹²⁸ Juries often find medical records to be of greater evidentiary weight than testimony alone.¹²⁹ Thus, physicians as well as patients benefited from the increase in record keeping attendant to the increase in malpractice litigation.

E. Standardization, Specialization, and Consolidation

The standardization of medical practice was preordained once *Pike v. Honsinger* set out the concept of standards of care.¹³⁰ Any physician deviating from the standard approach of the rest of the profession would be open to an accusation of practicing beneath the standard of care.¹³¹ Thus, inexorably, standardization of practice entered the medical field. Whether this stifled physician initiative or brought increased safety to the patient was, at the beginning, something of an open question.¹³²

As early as 1928, it was recommended that physicians use consultations as a protection against legal liability (or at least a way to “distribute responsibility”).¹³³ Since that time, courts have found that there exists a duty to refer a patient when the “practitioner discovers, or should know or discover, that the patient’s ailment is beyond his knowledge or technical skill, or ability or capacity to treat with a likelihood of reasonable success.”¹³⁴ This combination of a need to consult and a duty to refer has contributed to the widespread specialization seen in the human medical field.¹³⁵

During the first three decades of the twentieth century, the site of treatment for acute care shifted away from the home to the hospital.¹³⁶ Within the hospital environment, around-the-clock care meant that each patient was cared for by multiple doctors, nurses, and technicians who needed to effectively communicate the patient’s condition to one

¹²⁷ See *id.* at 74 (discussing a lawyer’s advice to physicians about keeping complete records to avoid malpractice lawsuits).

¹²⁸ *Id.*

¹²⁹ See *e.g.* Kaufman & Thomas, *supra* n. 115, at 227 (discussing a lawsuit where the jury returned a favorable verdict for the doctor, finding the medical records “more credible than the plaintiff’s denial of a referral”).

¹³⁰ Hogan, *supra* n. 64, at 29.

¹³¹ *Id.* at 70.

¹³² *Id.*

¹³³ *Id.* at 69.

¹³⁴ *Larsen v. Yelle*, 246 N.W. 2d 841, 845 (Minn. 1976).

¹³⁵ See *e.g.* C. Macpherson, *Undertreating Pain Violates Ethical Principles*, 35 J. Med. Ethics 603, 606 (2009) (explaining that the ethical duty to consult or refer patients to pain specialists leads to an increase in specialization as physicians are exposed to new information and become aware of their limited knowledge).

¹³⁶ Hogan, *supra* n. 64, at 91.

another.¹³⁷ As a result, medical records became an even more important part of medical care: They were the only way to ensure continuity of care for the patient.¹³⁸

The first half of the twentieth century thus saw the arrival of three major changes in the field of medicine—the standardization of medical care, the rise of specialties, and the consolidation of care in hospital type settings.

F. *Improvement of Care and Reduction of Errors*

One cannot dismiss the benefits of some of the changes in the field of medicine as discussed above. However, the real question regarding the effect of malpractice litigation is whether it achieved its stated goals—improvement of care, reduction in medical errors, or both. “Deterrence is the primary theoretical rationale for the tort liability system.”¹³⁹ Thus one would expect that the deterrent effect of the threat of medical malpractice litigation should have improved the quality of medical care. Unfortunately, there is a lack of empirical evidence that the threat of medical malpractice has done so.¹⁴⁰ “Medical errors remain frequent, even with the threat of tort claims.”¹⁴¹ Given that injury deterrence is typically listed as the first goal of tort liability, this is a “very serious deficiency.”¹⁴² Obviously, just because empirical evidence is lacking, it is not a given that malpractice litigation has had no beneficial effect on the quality of care. However, the lack of evidence suggests that, even if there is a beneficial effect, it is likely to be small.

G. *Physician Effects*

One of the effects of medical malpractice litigation that is often not factored into the quality of care discussion is the psychological effect of the threat of litigation on the physician. Clues to this psychological effect can be found in the fact that “[p]hysicians typically invest a great deal of emotion in the malpractice issue, usually to a degree that is out of proportion to the actual risk.”¹⁴³ In general, “[p]hysicians believe, in most cases rightfully so, that their devotion to patients runs deep.”¹⁴⁴ A lawsuit “is felt as a betrayal and can be an extremely stressful experience for the physician-defendant.”¹⁴⁵ Thus, malpractice suits “threaten the core of a physician’s self-esteem.”¹⁴⁶ Many physicians practice in fear of just this event—they “see every patient as a poten-

¹³⁷ *Id.* at 91–92.

¹³⁸ *Id.* at 91.

¹³⁹ Mello & Studdert, *supra* n. 78, at 17.

¹⁴⁰ Sloan & Chepke, *supra* n. 10, at 6.

¹⁴¹ *Id.* at 14.

¹⁴² *Id.* at 312.

¹⁴³ Brennan et al., *supra* n. 100, at 109.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* at 110.

¹⁴⁶ Gerald Dolman & Marjorie O. Thomas, *It’s Not Just About Avoiding the Lawsuit*, in *Practicing Medicine in Difficult Times* *supra* n. 115, at 16.

tial lawsuit.”¹⁴⁷ This naturally undermines their ability to give their all for the patient. Daily fear of litigation, rather than increasing the quality of care, has the very real chance of decreasing the quality of care as stressed doctors practice defensive medicine on their patients.

A very high percentage of physicians maintain that they practice defensive medicine of one sort or another on account of the threat of being sued.¹⁴⁸ Rather than feeling that they are practicing better medicine, health care providers generally “see no link between medical malpractice litigation and provision of high-quality care.”¹⁴⁹ Additionally, physicians who are sued are not necessarily worse physicians than those who are not.¹⁵⁰ Thus, there is a real question as to whether the majority of physicians see medical malpractice litigation as having any positive effect on them, medical practice, or society in general. This lack of appreciation for malpractice litigation is likely to exacerbate the psychological stress caused by the threat of litigation.

In addition to stress, there can be a significant loss of physician time in defending malpractice cases.¹⁵¹ The yearly cost of physician time spent on defending lawsuits has been estimated at more than \$100 million.¹⁵² However, the cost of the time spent defending a malpractice suit is likely to be only a small part of the psychological effect on a defendant doctor.

In 2003, nearly two-thirds of medical residents reported that liability issues were their “top concern” when choosing a field of medical specialty.¹⁵³ Rather than picking a field of medicine in which they were interested or for which they showed talent, these physicians felt that they needed to choose a specialty at least in part based on the desire to reduce the chance of being sued. This is hardly a sound starting point for a system that one would hope would produce talented and dedicated physicians who would be happy in their practice for decades to come.

Finally, the fear of liability is also deterring potential doctors from entering the field of medicine at all.¹⁵⁴ “One in four doctors presently completing their residency would select another profession than medicine if given the chance.”¹⁵⁵

There is no question that the threat of litigation has had a profound effect on the practice of medicine over the last hundred years. The real question is, have the benefits outweighed the harm?

¹⁴⁷ *Id.*

¹⁴⁸ Sloan & Chepke, *supra* n. 10, at 312.

¹⁴⁹ *Id.* at 313.

¹⁵⁰ *Id.* at 81.

¹⁵¹ *Id.* at 59.

¹⁵² *Id.* at 73.

¹⁵³ Anthony J. Bonomo, *The Power of Prevention*, in *Practicing Medicine in Difficult Times*, *supra* n. 115, at 2.

¹⁵⁴ Gerald L. Eichinger, *Veterinary Medicine: External Pressures on an Insular Profession and How Those Pressures Threaten to Change Current Malpractice Jurisprudence*, 67 *Mont. L. Rev.* 231, 241 (2006).

¹⁵⁵ *Id.*

V. A BRIEF HISTORY OF VETERINARY MALPRACTICE LITIGATION IN THE UNITED STATES

Litigation over veterinary malpractice in the U.S. is not new.¹⁵⁶ However, the amount of attention the topic has received in the press has increased dramatically over the last few decades.¹⁵⁷ It is not uncommon to see articles in mass media publications with titles such as *When Pets Die at the Vet, Grieving Owners Call Lawyers*,¹⁵⁸ *What to Do If You Suspect Vet Malpractice*,¹⁵⁹ and *Woof Woof, Your Honor*.¹⁶⁰ There are, as one might expect, websites dedicated to the issue of veterinary malpractice.¹⁶¹ A publication by the International Society for Animal Rights goes so far as to say that “veterinary malpractice . . . is without question the source of most harm to companion animals.”¹⁶² Thus, the exposure of veterinary malpractice to the general public has gone from being virtually nonexistent to being a commonplace occurrence.

Legal actions for veterinary malpractice in the U.S. extend to at least the middle of the nineteenth century. In one early case, the issue was harm caused to a horse as a result of “unskillfully lancing a hock,” which had rendered the horse worthless.¹⁶³ Early claims of veterinary malpractice involved harm to farm or working animals.¹⁶⁴ Companion animal malpractice cases were virtually unheard of until the last twenty years.¹⁶⁵ Since the mid-1980s, there have been increasing numbers of cases brought against veterinarians for malpractice with regard to companion animals.¹⁶⁶ In general, courts have been reluctant to award anything but economic damages, although they have sometimes been somewhat liberal in how they calculate those dam-

¹⁵⁶ See e.g. *Bekkemo v. Erickson*, 242 N.W. 617 (Minn. 1932) (finding that evidence was sufficient to justify an award of damages in a malpractice action for negligence for failing to diagnose hog cholera).

¹⁵⁷ Eichinger, *supra* n. 154, at 249.

¹⁵⁸ Laura Parker, USA Today, *When Pets Die at the Vet, Grieving Owners Call Lawyers*, http://www.usatoday.com/news/nation/2005-03-14-pets-malpractice_x.htm (updated Mar. 15, 2005) (accessed Nov. 20, 2010).

¹⁵⁹ Emily Messner, *What to Do if You Suspect Vet Malpractice*, Wash. Post M03 (Sept. 26, 2004) (available at <http://www.washingtonpost.com/wp-dyn/articles/A45754-2004-Sep23.html> (accessed Nov. 20, 2010)).

¹⁶⁰ Anita Hamilton, *Woof Woof, Your Honor*, 164 Time 46 (Dec. 13, 2004).

¹⁶¹ See e.g. Julie Catalano, *Veterinary Abuse Network*, <http://www.vetabusenetwork.com> (accessed Nov. 20, 2010) (a consumer advocacy website about veterinary malpractice).

¹⁶² Henry Mark Holzer, *Harming Companion Animals: Liability and Damages*, 2 (Inst. for Animal Rights L. 2006).

¹⁶³ *Conner v. Winton*, 8 Ind. 315 (Ind. 1856).

¹⁶⁴ See generally Green, *supra* n. 44, at 172–73 (describing laws about veterinary negligence related to “a beast or an ass” dating back to 1800 B.C.).

¹⁶⁵ Holzer, *supra* n. 162, at 1.

¹⁶⁶ *Id.*

ages—for example, awarding damages for the unique value of a pet to its owner.¹⁶⁷

There is some question regarding just how courts should handle veterinary malpractice. Most courts have analogized veterinary practice with human medical practice to “align their veterinary jurisprudence with human medical jurisprudence, adopting malpractice as a valid cause of action.”¹⁶⁸ Other courts have disagreed, reasoning that since there is no human patient-physician relationship upon which to base a malpractice action, a simple negligence standard is more appropriate.¹⁶⁹ In general, however, to establish a claim of veterinary malpractice, “the plaintiff must show a duty to conform to a certain standard of care, a failure to conform to a required standard, an actual injury, and a reasonably close causal connection between the conduct and the injury.”¹⁷⁰

In recent years, plaintiffs have brought veterinary malpractice cases under a number of noneconomic damage theories. These include loss of companionship, pain and suffering, negligent infliction of emotional distress (NIED), intentional infliction of emotional distress (IIED), and wrongful death, among others.¹⁷¹

Two recent decisions give an example of how courts have dealt with these types of cases. In *McMahon v. Craig*, an attorney sued her veterinarian after her dog died in the veterinarian’s care.¹⁷² She alleged veterinary malpractice, negligent failure to inform, intentional misrepresentation, negligent misrepresentation, constructive fraud, conversion, and intentional infliction of emotional distress.¹⁷³ In dismissing the plaintiff’s claims, the court cited the difficulty in identifying a class of animals that warrant noneconomic damages:

[E]xtending emotional distress [and other noneconomic] damages to owners of companion pets based on veterinary malpractice would have unknown consequences on both the cost and availability of veterinary care. Indeed, defining the limits of potential liability would be difficult. Because humans are not related to pets, limits cannot be based on degree of consanguinity. Is every family member residing with the pet a human companion and potential plaintiff? Moreover, what pets would qualify as companion animals? Few would dispute the long-standing bond between humans and dogs, but limiting emotional distress damages to dog owners would affront those who love cats. Few would consider livestock companion animals, but

¹⁶⁷ *McDonald*, 644 N.E.2d at 752.

¹⁶⁸ Kim Eileen Bell, Student Author, *Nelson v. State Board of Veterinary Medicine: The Commonwealth Court Carves a Sharper Definition of Veterinary Malpractice*, 16 *Widener L.J.* 473, 477 (2007).

¹⁶⁹ *Id.* at 476–77; *Southall v. Gabel*, 277 N.E.2d 230, 232 (Ohio App. 1971).

¹⁷⁰ 78 *Am. Jur. 2d Veterinarians* § 7 (2002).

¹⁷¹ Richard L. Cupp, Jr. & Amber E. Dean, *Veterinarians in the Doghouse: Are Pet Suits Economically Viable?*, 31 *The Brief* 43, 44, 46, 48 gr. (2002); see also 22A *Am. Jur. 2d Death* § 221 (2003) (discussing loss of companionship as a type of wrongful death action).

¹⁷² *McMahon v. Craig*, 176 Cal. App. 4th 1502, 1506 (2009).

¹⁷³ *Id.* at 1508.

consider the facts in *Krasnecky*, in which the “plaintiffs regarded the[ir] sheep as their ‘babies’ and spent six or seven hours a day with them, giving them names and celebrating their birthdays with special food and balloons. They patted, hugged, and brushed the sheep and baked snacks for them.” As one court noted, “it would be difficult to cogently identify the class of companion animals because the human capacity to form an emotional bond extends to an enormous array of living creatures.”¹⁷⁴

The court also ruled that the defendants’ alleged acts of malpractice did not meet the prerequisites for an IIED claim because they were neither directed at McMahon nor were they done in her presence.¹⁷⁵

The Supreme Court of Vermont reached a similar result in *Goodby v. Vetpharm*.¹⁷⁶ In this case, incorrectly compounded medication led to fatal overdoses of two cats.¹⁷⁷ The plaintiffs sought compensation for the lost companionship and society of their animals, and “for emotional distress at having been made the unwitting agents of their pets’ demise.”¹⁷⁸ The Court rejected the plaintiffs’ claims:

Plaintiffs fail to demonstrate a compelling reason why, as a matter of public policy, the law should offer broader compensation for the loss of a pet than would be available for the loss of a friend, relative, work animal, heirloom, or memento—all of which can be prized beyond measure, but for which this state’s law does not recognize recovery for sentimental loss.¹⁷⁹

Additionally, the Court said that the plaintiffs could not recover for NIED because they were “never the objects of the allegedly negligent acts of the veterinarians and pharmacy, and thus were neither in physical danger themselves, nor had any reason to fear for their own physical well-being.”¹⁸⁰

In the above cases, both courts found that the elements of the infliction of emotional distress claims were not met by the plaintiffs. The courts also used public policy rationales to deny recovery for noneconomic damages in both cases. These rulings are in line with the vast majority of cases seeking noneconomic damages for harm to pets in the veterinary malpractice setting.¹⁸¹

Organized veterinary medicine has, in general, agreed with this approach. The policy statement promulgated by the American Veterinary Medical Association (AVMA) on this issue flatly rejects noneconomic damages:

The American Veterinary Medical Association recognizes and supports the legal concept of animals as property. However, the AVMA recognizes that

¹⁷⁴ *Id.* at 1514–15 (citation omitted).

¹⁷⁵ *Id.* at 1516.

¹⁷⁶ *Goodby*, 974 A.2d at 1274.

¹⁷⁷ *Id.* at 1272.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at 1274.

¹⁸⁰ *Id.*

¹⁸¹ Eichinger, *supra* n. 154, at 247.

some animals have value to their owners that may exceed the animal's market value. In determining the real monetary value of the animal, the AVMA believes the purchase price, age and health of the animal, breeding status, pedigree, special training, veterinary expenses for the care of the animal's injury or sickness, related to the incident in question, and any particular economic utility the animal has to the owner should be considered. Any extension of available remedies beyond economic damages would be inappropriate and ultimately harm animals. Therefore, the AVMA opposes the potential recovery of non-economic damages.¹⁸²

However, noneconomic damages continue to be sought. Green suggests that "loss of companionship is the most uniform, consistent, and administrable of all the existing causes of action for loss of a companion animal due to veterinary negligence,"¹⁸³ and that damages should, due to "political reality," be capped at \$25,000.¹⁸⁴ Given Eichinger's estimate that it costs \$20,000 to \$25,000 to bring a veterinary malpractice case through to a verdict,¹⁸⁵ a \$25,000 damage cap is high enough to increase the likelihood that malpractice cases will be brought, thus inviting the changes in veterinary medicine discussed in this paper.

As the courts discussed above, awarding damages for loss of companionship of an animal would also introduce the inequity that such awards are not available for harm to many humans.¹⁸⁶ For example, in denying damages for loss of companionship for injury to a parent, the Minnesota Supreme Court stated:

We are keenly aware of the need of children for the love, society, COMPANIONSHIP, and guidance of their parents; any injury that diminishes the ability of a parent to meet these needs is clearly a family tragedy and harms all members of that community. We conclude, however, that based on our own precedent and on considerations of public policy and the results that would obtain upon recognition of this type of claim, such as the additional burden placed on society through increased insurance costs and the added expense of litigation and settlement, and in the interest of limiting the legal consequences of a wrong to a controllable degree, a new cause of action on behalf of a child for the LOSS of parental consortium should not be recognized.¹⁸⁷

Similarly, many courts have adopted the position that parents cannot recover damages for the loss of consortium of their negligently injured child.¹⁸⁸ Courts have also commonly denied recovery for loss of consortium of a child to stepparents, siblings, grandparents, and

¹⁸² AVMA, *AVMA Policy, Compensatory Values for Animals Beyond Their Property Value*, http://avma.org/issues/policy/compensatory_values.asp (accessed Nov. 20, 2010).

¹⁸³ Green, *supra* n. 44, at 241.

¹⁸⁴ *Id.* at 242–43.

¹⁸⁵ Eichinger, *supra* n. 154, at 236.

¹⁸⁶ *Goodby*, 974 A.2d at 1273.

¹⁸⁷ *Salin v. Kloempken*, 322 N.W.2d 736, 742 (Minn. 1982).

¹⁸⁸ Todd R. Smyth, *Parent's Right to Recover for Loss of Consortium in Connection with Injury to Child*, 54 A.L.R. 4th 112, 116 (1987).

others.¹⁸⁹ Given these rulings, it would seem that allowing actions for loss of companionship of a pet could create situations in which there would be greater legal remedy for harm to the family pet than for harm to a human member of that family.

There are in excess of 2,000 cases alleging veterinary malpractice filed in U.S. courts annually.¹⁹⁰ The fact that damages in such cases have routinely been limited to the economic value of the pet—however that value is calculated—means that “pet owners seeking contingent fee representation for allegations of veterinary malpractice have been largely unsuccessful in finding an attorney to take their case.”¹⁹¹ Without these limitations on awards, the likelihood of increased litigation in the veterinary malpractice arena is almost certain. As one commentator states, “if courts . . . permit animal owners to sue for emotional distress damages, loss of companionship damages, and other noneconomic damages related to the injury to or loss of a pet, then the practice of veterinary medicine . . . will be forever altered.”¹⁹²

VI. PREDICTION OF THE EFFECTS OF INCREASED LITIGATION ON THE FIELD OF VETERINARY MEDICINE

As discussed above, the combination of increased technology, high patient expectations, medical malpractice insurance, and large damage awards led to widespread and substantial changes in the practice of physicians and hospitals. Currently, three of those factors are applicable to veterinary medicine, with large damage awards in veterinary malpractice litigation the only rarity.¹⁹³ It is reasonable to believe that the awarding of damages substantial enough to financially encourage increased litigation will result in similarly widespread and substantial changes in the field of veterinary medical practice.

Veterinary medicine has many things in common with human medicine, while having several significant differences as well. Commonalities with the human medical field will likely lead to litigation having similar effects on the field of veterinary medicine as it has had on the field of human medicine. Differences between veterinary medicine and human medicine may have the effect of causing differing reactions to litigation in veterinary medicine than in human medicine.

A. *Malpractice Insurance*

The effect of noneconomic damage awards on the cost of veterinary malpractice insurance has received much attention, with at least one law review article focusing extensively on this topic.¹⁹⁴ Currently

¹⁸⁹ Elizabeth Trainor, *Who Other Than Parent, May Recover For Loss of Consortium on Death of Minor Child*, 84 A.L.R. 5th 687 (2000).

¹⁹⁰ Eichinger, *supra* n. 154, at 234.

¹⁹¹ *Id.* at 236.

¹⁹² Nunalee & Weedon, *supra* n. 36, at 145.

¹⁹³ Green, *supra* n. 44, at 176–77.

¹⁹⁴ *Id.* at 163.

the majority of veterinarians are insured for liability by the professional liability insurance trust of the American Veterinary Medical Association (AVMA PLIT).¹⁹⁵ The cost of liability insurance for companion animal (small animal exclusive) veterinarians is \$234 per year for insurance up to \$1 million.¹⁹⁶ Green argues that “the fact that veterinary malpractice insurance prices are extremely low . . . indicates a disruption in the optimal functioning of the market.”¹⁹⁷ He further states that:

[While] such artificial price controls benefit veterinarians in the short term, it is pet owners, not veterinarians, who are the true consumers of malpractice insurance. To explain, professional malpractice insurers invariably recover any lawsuit damages paid out by increasing the premiums charged to those whom they insure—in this instance, veterinarians. In turn, those insured professionals pass these premium increases on to the client consumers of their services—in this case, pet owners. Accordingly, pet owners are both the collective *purchasers* of veterinary liability insurance and the individual *beneficiaries* when negligent accidents occur.¹⁹⁸

Thus, “even if pet owners are willing to pay far more than their current [12¢] premium in order to purchase greater protection against veterinary malpractice, courts are prohibiting them from doing so and thereby interfering with the forces of the free market economy.”¹⁹⁹ Green goes on to say that if “veterinary liability insurance rates truly ‘skyrocketed’ by 100 times their current level to a whopping \$18,800 . . . even then, when one does the math, that total premium comes out to an annual veterinary care cost increase of \$11.50 per pet-owning household.”²⁰⁰ This is presumably an amount that “even the most impoverished pet owner[s]” would be willing to pay in exchange for the opportunity to sue their veterinarians for noneconomic damages.²⁰¹

Not all commentators agree with Green’s rosy view of the effects of increased litigation on the cost of veterinary malpractice insurance. For example, Nunalee and Weedon believe that, in response to increased damage awards, “veterinary malpractice insurance premiums will likely increase substantially, resulting in greater overhead.”²⁰² Schwartz and Laird appear to agree, adding that increased awards may even cause companies to leave the veterinary insurance field.²⁰³ If companies do indeed exit from the veterinary insurance field or in-

¹⁹⁵ *Id.* at 175.

¹⁹⁶ AVMA PLIT, *Annual Premiums Effective Jan. 1, 2010*, http://avmaplit.com/uploadedFiles/AVMAPLIT/Top_Navigation/Shared_Resources/2010%20Rate%20Card%20and%20App%281%29.pdf (accessed Nov. 20, 2010).

¹⁹⁷ Green, *supra* n. 44, at 177.

¹⁹⁸ *Id.* at 178.

¹⁹⁹ *Id.*

²⁰⁰ *Id.* at 219.

²⁰¹ *Id.* at 221.

²⁰² Nunalee & Weedon, *supra* n. 36, at 159.

²⁰³ Schwartz & Laird, *supra* n. 19, at 261.

crease their rates dramatically, the possibility arises that veterinary medicine could find itself faced with a situation similar to the malpractice insurance crises that have beset the human medical field in the last thirty years. Since individual veterinarians and small group practices tend not to have the depth of financing that is available in human medicine,²⁰⁴ they may not be able to weather a malpractice crisis as well as human medical providers.

No matter whose view one takes as correct, the consensus seems clear: The cost of malpractice insurance for veterinarians will inevitably rise with any increase in the number of lawsuits or the amount of damages awarded.

B. Defensive Medicine

It seems clear from the human medical experience that defensive medicine is a common byproduct of the threat of litigation. Green states that the arrival of defensive medicine in veterinary practice “is probably the strongest of the arguments against increasing the negligence liability of veterinarians.”²⁰⁵ However, he goes on to say that “veterinarians also may discover that what they now refer to as defensive medicine may be viewed by consumers as simply providing optimal care.”²⁰⁶ Unfortunately, this last comment may be well-taken. It is a well-known problem that many veterinarians try to protect their clients’ pocketbooks by recommending the minimum diagnostic testing possible.²⁰⁷ This can result in significant detriment to the veterinarian-client interaction and lead to poor outcomes.²⁰⁸ Part of this is a response to a perceived reluctance on the part of clients to pay for the treatment of their pets.²⁰⁹

Articles in some “consumer” magazines help reinforce this perception by recommending that people search for inexpensive veterinary care.²¹⁰ An article by *Consumer Reports* states that veterinary fees are “influenced by how much in college loans a newly minted vet has to pay off, how new or fancy the vet’s office is, and whether the office, which vets often call an animal hospital, is located in a high-rent part

²⁰⁴ Mike Richards, VetInfo, *Support Your Local Veterinary Hospital*, <http://www.vetinfo.com/supportvet.html> (accessed Nov. 20, 2010).

²⁰⁵ Green, *supra* n. 44, at 221–22.

²⁰⁶ *Id.* at 223.

²⁰⁷ Kristi Reimer, *Affordability vs. Excellence: Do Veterinarians Have to Choose?*, 50 *Veterinary Econ.* 5, 5 (2009).

²⁰⁸ Jason B. Coe et al., *A Focus Group Study of Veterinarians’ and Pet Owners’ Perceptions of the Monetary Aspects of Veterinary Care*, 233 *J. Am. Veterinary Med. Assn.* 1072, 1074 (2007) [hereinafter Coe et al., *Monetary Aspects Study*].

²⁰⁹ Claire Duffett, *Pet Insurance Targets Voluntary-Care Market*, *All Business*, <http://www.allbusiness.com/north-america/united-states-new-york/919379-1.html> (Dec. 16, 2005) (accessed Nov. 20, 2010).

²¹⁰ Consumers Union of U.S., Inc., *ConsumerReports.org, Veterinary Care Without the Bite*, <http://www.consumerreports.org/Pets/> (July 2003) (accessed Nov. 20, 2010); *Veterinarians*, 1 *Twin Cities Consumers’ CHECKBOOK* 26 (2003) [hereinafter *Checkbook*].

of town.”²¹¹ That article also suggests that “vets’ reliance on tests in place of their instincts” may be a cause of higher fees.²¹² Another article asserts that “you can be reasonably sure that any veterinarian you might choose is intelligent and well trained” and thus by price shopping it is possible to save money and also get top-quality care for your pet.²¹³ It is hardly a surprise when some veterinarians take this to heart and try not to “oversell” their services.

Articles like these tend to treat veterinary care as a fungible commodity. In reality, however, health care, whether human or veterinary, is not the same as a can of pickled beets. Unlike canned beets, people cannot base their pet care decisions on price alone. For example, a “spay” surgery (ovariohysterectomy) is not the same at every veterinary facility. Differences include such things as the types of anesthesia and analgesia used, skill of the surgeon, quality of nursing care, whether there is anesthetic monitoring, whether presurgical blood testing is performed, and whether an intravenous catheter and fluid support are used.²¹⁴ To perform a “spay,” all that is really needed is some sort of anesthesia and some very basic and inexpensive equipment.²¹⁵ However, to perform a “spay” that maximizes the likelihood of a successful outcome, minimizes the pain and stress experienced by the patient, and meets the standards of the American Animal Hospital Association (AAHA), significant skill and expensive equipment are required.²¹⁶ Thus, a client who does not understand that these two procedures with the same name are in actuality very different will not be able to make an informed decision as to which “spay” is right for them.

The article in CHECKBOOK magazine goes on to say that the major result of “going to an [AAHA] accredited firm [is that it] might cost you more.”²¹⁷ The AAHA is the only organization that accredits small animal veterinary facilities in the United States.²¹⁸ Accreditation is

²¹¹ Consumers Union of U.S., Inc., *supra* n. 210.

²¹² *Id.*

²¹³ *Checkbook*, *supra* n. 210, at 26.

²¹⁴ Andrea Bivens, Charlotte Sun, *Difference Between High- and Low-Cost Spays*, <http://www.yoursun.com/sunnews/portcharlotte/portcharlottecolumntist/1469782-445/story.csp> (Sept. 15, 2010) (accessed Nov. 20, 2010); Mount Rose Animal Hospital, *Canine and Feline Spaying*, http://www.mountrosevets.com/index_files/Page600.htm (accessed Nov. 20, 2010).

²¹⁵ SPAY/USA, *To Start a Low-Cost Spay/Neuter Clinic*, http://www.spayusa.org/main_directory/03-programs_and_clinics/start_a_clinic.asp (accessed Nov. 20, 2010).

²¹⁶ See AAHA, *AAHA Accreditation, AAHA Importance to You and Your Pet*, <http://www.healthypet.com/Accreditation/AboutAAHA.aspx> (accessed Nov. 20, 2010) [hereinafter AAHA, *About AAHA*] (stating that AAHA accreditation requires components such as x-rays and laboratories, and it keeps veterinary hospitals on the leading edge of veterinary medicine); AAHA, *AAHA Accreditation, Accreditation Matters: Surgical Protocols Reassure Pet Owners*, http://www.healthypet.com/Accreditation/StandardArticle.aspx?art_key=e83830dc-6a0c-41b3-beb6-ac0cd80c7ac5 (accessed Nov. 20, 2010) (summarizing AAHA surgical protocols).

²¹⁷ *Checkbook*, *supra* n. 210, at 29.

²¹⁸ AAHA, *AAHA Accreditation*, <http://www.healthypet.com/Accreditation/Default.aspx> (accessed Nov. 20, 2010) [hereinafter AAHA, *Accreditation*].

based on an evaluation of 900 standards and is voluntary.²¹⁹ The standards include evaluation of quality of care; diagnostic and pharmacy capacities; management; medical records; and facility.²²⁰ Specifically, the standards require veterinary hospitals to “provide diagnostic services (x-ray and laboratory) . . . and focus on the quality of care in the areas of: anesthesia, contagious diseases, dentistry, pain management, patient care, surgery, and emergency care.”²²¹ The standards developed and published by AAHA are widely accepted as representing those components of veterinary practice that provide high-quality care.²²² Because of the rigors of complying with the AAHA standards, only about 15% of companion animal hospitals are AAHA accredited.²²³

It seems very possible that an increased threat of litigation will increase the number of veterinarians seeking to defend themselves by practicing to the standard of care endorsed by AAHA. This may well be of great benefit to the individual patient. It may well also support Green’s argument that these changes are really just “providing optimal care” rather than being defensive medicine.²²⁴ However, the costs associated with “providing optimal care” are very real and will be borne by the pet owner.

Pet owners tend to have widely varying desires to pay for veterinary care for their pets. For some, even those with limited funds, complete preventative and remedial care is a given for their pets. For others, a rabies shot to avoid a problem with the local animal control officer is all they choose to have done. This tends to contrast sharply with how people approach their own health care. Most humans will seek medical attention at the very least when they are in pain or fear that something is significantly wrong with their health. The same is not always true for their pets. One industry publication states that “the determining factor affecting client behavior seems to be how the person feels about the pet rather than how much money he or she has.”²²⁵ This is backed up by studies that show that owners with strong bonds to their pets seek higher levels of veterinary care compared to owners with weaker bonds to their pets.²²⁶ In some cases, there can also exist “an element of suspicion among [some] pet owners

²¹⁹ AAHA, *About AAHA*, *supra* n. 216.

²²⁰ *Id.*

²²¹ *Id.*

²²² AAHA, *Accreditation*, *supra* n. 218.

²²³ AAHA, *AAHA Accreditation, Accreditation Matters: Healthier Practices, Healthier Pets*, http://www.healthypet.com/Accreditation/StandardArticle.aspx?art_key=59016c7c-d69b-433f-8168-248d58e08571 (accessed Nov. 20, 2010).

²²⁴ Green, *supra* n. 44, at 223.

²²⁵ Advanstar Communications, DVM360.com, *Helping Clients Pay in Difficult Times*, <http://veterinarybusiness.dvm360.com/vetec/ArticleStandard/Article/detail/634472> (Oct. 15, 2009) (accessed Nov. 20, 2010).

²²⁶ Todd W. Lue et al., *Impact of the Owner-Pet and Client-Veterinarian Bond on the Care that Pets Receive*, 232 *J. Am. Veterinary Med. Assn.* 531, 532 (2008).

in relation to the motivation driving [veterinarians'] recommendations" for pet health care.²²⁷

Veterinarians have to deal with these divergent pet care philosophies and associated issues on a daily basis. Many fear that they may negatively impact their relationship with their clients if they recommend optimal care for their pets.²²⁸ Green suggests that a way to deal with this problem is that "instead of ordering expensive, redundant diagnostics or treatments, veterinarians could protect themselves adequately through the increased use of consent forms commonly utilized in the practice of human medicine."²²⁹ This is certainly a potential partial solution to this problem. However, tailoring consent forms to the myriad of situations that may be encountered may well be a daunting task. Taking the time to explain the forms and the potential consequences of following or not following a recommended diagnostic or treatment plan will also add cost to the veterinary provider, which will presumably be passed along to the client. Veterinary appointments can be as short as ten to twelve minutes long,²³⁰ especially in those practices catering to clients that want low-cost care. Lack of time to thoroughly discuss diagnostic and therapeutic options has been cited as a significant problem.²³¹ How much more time will it take to make sure clients understand all the care options that they are declining to accept? And what negative impact will it have on those who believe that their veterinarian is trying to oversell services?

Higher quality practices tend to have longer appointment times²³² and are likely already utilizing forms and recommending optimal care for their patients. They also tend to charge significantly more for their services than other veterinarians.²³³ Thus, it is the "low-cost" veterinarians that will likely be most profoundly affected by these sorts of changes.

²²⁷ Coe et al., *Monetary Aspects Study*, *supra* n. 208, at 1516.

²²⁸ See Myrna Milani, MMillani.com, *Meaningful Client Communication*, <http://www.mmillani.com/meaningful-client-communication.html> (accessed Nov. 23, 2010) (observing that cost of treatment is a "major concern" for some clients and that some veterinarians fear being perceived by their clients as "money-hungry").

²²⁹ Green, *supra* n. 44, at 222.

²³⁰ Jane R. Shaw et al., *Veterinarian-Client-Patient Communication Patterns Used During Clinical Appointments in Companion Animal Practice*, 228 *J. Am. Veterinary Med. Assn.* 714, 718 (Mar. 1, 2006).

²³¹ Jason B. Coe et al., *A Focus Group Study of Veterinarians' and Pet Owners' Perceptions of Veterinarian-Client Communication in Companion Animal Practice*, 233 *J. Am. Veterinary Med. Assn.* 1072, 1076 (Oct. 1, 2008) [hereinafter Coe et al., *Communication Study*].

²³² See Terry Jackson, *The Veterinary Industry in Transition*, <http://www.vetadvise.com/PDFs/The%20Veterinary%20Industry%20In%20Transition.pdf> (accessed Nov. 20, 2010) (asserting that successful veterinary practices extend appointment times from fifteen minutes to half an hour).

²³³ See e.g. Choosing Voluntary Simplicity, *The High Cost of Veterinary Care*, <http://www.choosingvoluntarysimplicity.com/the-high-cost-of-veterinary-care/> (accessed Nov. 23, 2010) (one pet owner recounts how her previous veterinarian was considerably less expensive but also provided minimal care).

It is more than likely that increased financial liability in the veterinary medical field will lead to increases in recommended tests and other services. Unlike the human medical field, where third-party insurance is widespread,²³⁴ veterinary clients will end up personally footing the bill for these increased services. Also, unlike practitioners in the majority of human medical fields, veterinarians cannot interview their patients about how they are feeling. As Nunalee and Weedon state, “animals cannot communicate in human language the nature of their symptoms to their veterinarians, raising obvious challenges.”²³⁵ One of the challenges is that the history the veterinarian receives from the pet’s owner is often vague and may be of little help in narrowing down which diagnostic tests are most appropriate.²³⁶ In the past, veterinarians have often used their best medical judgment to help narrow down which tests to perform.²³⁷ However, if defensive medicine becomes the norm in veterinary practice, this will likely change. Because of the lack of information from the patient, a wide spectrum of testing may be required to ensure that all possibilities are covered and that liabilities are minimized. Thus, even more than in human medicine, a need to practice defensive medicine in the veterinary field may increase testing and, consequently, increase costs to the client dramatically.

In addition to the practice of positive defensive medicine, the possibility of negative defensive medicine, or avoidance behavior, must also be considered. In this context, negative defensive medicine would include such things as refusing to see certain types of cases, pets, or clients; unnecessary referrals to specialists; and leaving practice in particular areas or leaving the field of veterinary medicine entirely. As discussed above, it is common for physicians to react to the threat of malpractice litigation by limiting the scope of their practice by excluding certain types of cases or avoiding high-risk procedures.²³⁸ There is no reason to believe that, faced with similar liability concerns as the human medical community, veterinarians would behave any differently than their human medical counterparts. In fact, given the relative risk-reward ratio, veterinarians may display even more avoidance behavior.

To illustrate this point, a spay (ovariohysterectomy) can cost “anywhere from less than \$100 in a Humane Society, to several hundred

²³⁴ See Joanna Turner et al., *A Preliminary Evaluation of Health Insurance Coverage in the 2008 American Community Survey*, 8 (Sept. 22, 2009) (available at http://www.census.gov/hhes/www/hlthins/data/acs/2008/2008ACS_healthins.pdf) (accessed Nov. 20, 2010) (explaining that 84.9% of non-institutionalized civilians had health insurance coverage in 2008; 69.6% of non-institutionalized citizens had private health insurance).

²³⁵ Nunalee & Weedon, *supra* n. 36, at 149.

²³⁶ Sarah Anne Murphy, *Consumer Health Information for Pet Owners*, 94(2) *J. Med. Lib. Assn.* 152, 153 (Apr. 2006).

²³⁷ Otto M. Radostits et al., *Veterinary Clinical Examination and Diagnosis* 38 (WB Saunders 2000).

²³⁸ Brennan et al., *supra* n. 100, at 105.

dollars at a private veterinary clinic; however, a similar hysterectomy performed by a physician in a hospital is over \$15,000. If the ovaries are removed in a woman, this increases the cost by another \$17,440.”²³⁹ Thus, a veterinarian would charge approximately a hundredth of what a human medical counterpart would charge. Yet, the veterinarian would have similar liability issues to the medical doctor. It is hard to imagine many rational actors being willing to take the same risk for a hundredth of the reward. Thus, it is not unlikely that the field of veterinary medicine would be even more prone to widespread avoidance behaviors than is the field of human medicine. The particularly severe avoidance behavior of leaving (or refusing to enter) the field of veterinary medicine will be discussed below.

However hard it may be to predict the extent of the changes that increased litigation in the veterinary field will have, it will almost certainly result in increases in the practice of both positive and negative defensive medicine. Whether that may be beneficial, as Green would argue, or a serious problem, is unknown. However, the bottom line, as Nunalee and Weedon state in no uncertain terms, is that “[t]he veterinarian must learn the art of practicing defensive medicine.”²⁴⁰

C. Doctor-Patient Communication

In the field of veterinary medicine, the major concern regarding liability stemming from communication problems is, of course, with the client, not the patient. Other than that difference, issues that veterinarians face regarding communication are similar to those faced by medical doctors. As in human medicine, good communication in veterinary medicine is frequently mentioned as a way to avoid legal problems.²⁴¹ Additionally, “the manner in which a veterinarian communicates with a client has the potential to affect patient care, client satisfaction, and adherence to veterinarian recommendations.”²⁴² Better communication between veterinarian and client results in a stronger bond between the two, and, ultimately, in better care for the pet.²⁴³ To the extent that increased threat of litigation would encourage better communication between veterinarians and their clients, it would be beneficial. Unfortunately, the practices that spend the least amount of time with their clients in order to charge lower fees would likely be disproportionately affected.

Studies in human medicine have shown that cultivating a good relationship with patients and a good bedside manner may be an effective way to avoid being sued for malpractice,²⁴⁴ which raises some con-

²³⁹ Eichinger, *supra* n. 154, at 237.

²⁴⁰ Nunalee & Weedon, *supra* n. 36, at 149.

²⁴¹ Charlotte A. Lacroix, Veterinary Business Advisors, Inc., *Malpractice Risks . . . Where Are They?*, <http://veterinarybusinessadvisors.com/up/file/Malpractice.pdf> (accessed Nov. 20, 2010).

²⁴² Shaw et al., *supra* n. 230, at 715.

²⁴³ Lue et al., *supra* n. 226, at 532.

²⁴⁴ Sloan & Chepke, *supra* n. 10, at 77.

cerns for veterinary medicine. There is no question that these are good qualities for any doctor, whether M.D. or D.V.M. However, this effect may be even more prominent in veterinary medicine. Studies have shown that people rarely sue doctors they like.²⁴⁵ In the human medical field, patients perceive whether they like their doctors; they also perceive how they feel after treatment. Both of these factors inform patients' decisions as to whether they would consider suing the doctor for malpractice.²⁴⁶

In the veterinary medical field, clients also perceive whether they like their veterinarian; they also judge how their pet feels after treatment. Clients have no true firsthand experience informing how well the veterinarian has addressed their pet's problem. For example, if a person went to an endodontist to have a root canal performed for a broken tooth, that person would know if the root canal was successful or if there was still pain after the procedure. However, if a dog has a root canal, only the dog is likely to know that there is still pain after an inadequate procedure. Clients are in a poorer position to evaluate the success or failure of treatments performed on their pets than they are in evaluating the success or failure of their own medical treatments. This fact would tend to increase the influence that a veterinarian's "bedside manner" would have on a client's decision whether to sue. This would conversely tend to minimize the influence that the actual medical outcome had on that decision. Any tendency to make such a decision more on "bedside manner" than on actual outcome undermines the logical rationale for allowing malpractice litigation in the first place.

One communication issue that tends to be much more of a problem in veterinary medicine than in human medicine is that frequently more than one person is involved in the care of the patient.²⁴⁷ In one study, 70% of respondents stated that they shared responsibility for the care of their pet with someone else in their household.²⁴⁸ This has the potential to create a significant problem if the two owners do not agree on a course of action, or if one of the owners gives consent to a procedure or spends an amount of money that the other owner is unhappy about. This sort of problem occurs on a frequent basis in veterinary medicine since typically only one owner brings the pet to the doctor's office.²⁴⁹ Usually, there are only minor effects on the veterinary practice. However, at least one published case illustrates that that this conflict can lead to litigation. In *Ferrell v. Trustees of the University of Pennsylvania*, veterinarians told the plaintiff's husband that their cat had leukemia.²⁵⁰ The husband authorized euthanasia, which was subsequently performed. When his wife learned of the decision,

²⁴⁵ Schwartz & Donohue, *supra* n. 121, at 69.

²⁴⁶ *Id.* at 68–69.

²⁴⁷ Lue et al., *supra* n. 226, at 533.

²⁴⁸ *Id.*

²⁴⁹ *Id.*

²⁵⁰ 1994 U.S. Dist. LEXIS 17740 at **1–2 (E.D. Pa. Dec. 12, 1994).

she sued the veterinarians.²⁵¹ The dynamics of some relationships may make it more palatable for unhappy spouses to redirect their anger from their spouse to a veterinarian. If noneconomic damages are a possible award, the frequency of such suits will likely increase.

Another factor that differentiates veterinary medicine from human medicine is the fact that most people who utilize veterinary services pay for those services out of their own pocket.²⁵² Third party insurance is still very uncommon in veterinary medicine as compared to human medicine.²⁵³ It is even more uncommon for veterinary insurance to be provided for people as an employment benefit.²⁵⁴ In human medicine, “[p]atients who do not have a good outcome after elective surgery are more likely to sue the doctor, especially if they have paid cash for or taken a loan to finance the procedure.”²⁵⁵ The same is likely true in veterinary medicine.

Unlike human medical care, veterinary care is largely elective. This would seem odd given that some states specifically mention a requirement for veterinary care in their anticruelty statutes.²⁵⁶ However, these statutes vary widely in the acts or omissions that are covered and the penalties that apply for violations.²⁵⁷ In spite of these statutes, essentially all veterinary treatment is “elective” in that pet owners are generally not forced to obtain it. This is primarily due to the fact that prosecution under anticruelty statutes is very problematic. In a case brought under the New York state animal cruelty statute, the court discussed some of these problems, and posed a number of difficult questions, such as:

[H]ow is the standard of medical care that must be provided to be determined? (i.e., To what extent must treatment be provided to avoid prosecution? Is providing regular veterinary care sufficient? Or, in light of the sophisticated medical procedures that are now available for animals—chemotherapy, radiation therapy, organ transplants—will that level of treatment be required? Will mental health treatment be required?); and how would that standard be judged? (What kind of expense is it mandated to be incurred to avoid prosecution?) It will also create ethical issues that are difficult to discern in the absence of a legislative pronouncement (When

²⁵¹ *Id.* at *2.

²⁵² See John Volk & Christine Merle, *A Veterinarian's Guide to Pet Health Insurance: How Pet Insurance Affects the Practice, the Client and the Patient*, 3 (available at <http://www.ncvei.org/articlelinks/VetInsBroJan9.pdf> (accessed Nov. 20, 2010)) (showing that only 5% of surveyed pet owners who visited their veterinarian in the past year said they had pet health insurance).

²⁵³ *Id.*

²⁵⁴ See Socy. for Hum. Res. Mgt., *2010 Employee Benefits: Examining Employee Benefits in the Midst of a Recovering Economy* 39 (available at <http://www.shrm.org/Research/SurveyFindings/Articles/Documents/10-0280%20Employee%20Benefits%20Survey%20Report-FNL.pdf> (accessed Nov. 20, 2010)) (showing that 4% of private employers offer pet health insurance as an employee benefit).

²⁵⁵ Bonomo, *supra* n. 153, at 6–7.

²⁵⁶ Phyllis Coleman, *Man's Best Friend Does Not Live by Bread Alone: Imposing a Duty to Provide Veterinary Care*, 12 *Animal L.* 7, 30 (2005).

²⁵⁷ *Id.*

is extending a pet's life permissible? When is putting an animal to death mandated? Up to what point do we respect the owners' choice to refuse invasive treatment for their pets and allow them to die at home in the company of their human and non-human companions, rather than in a strange and antiseptic environment?).²⁵⁸

The difficulty of answering these questions led the court to find in favor of the defendant.²⁵⁹ Even in a case that was prosecuted to a conviction, Justice Lopez stated in her concurrence on the judgment, "If there was ever a case that screamed for prosecutorial discretion, it is this case."²⁶⁰

In addition to being *de facto* elective procedures, essentially all veterinary services are paid in cash or from loans.²⁶¹ Clients often make the initial decision to pay for veterinary care based on emotion, but once "the situation is resolved and the emotions have dissipated, they begin to make decisions on the basis of financial considerations."²⁶² Thus, it may be that people will be more likely to sue their veterinarians when an outcome is not to their liking than they would be to sue their physician. This would exacerbate the effects of increasing awards for veterinary malpractice.

D. Record Keeping

The AVMA policy statement provides that veterinary medical records "are an integral part of veterinary care," and that "[t]he records must comply with the standards established by state and federal law."²⁶³ Typically, state veterinary medical boards promulgate standards regarding medical records. For example, the Minnesota Board of Veterinary Medicine requires that any "veterinarian performing treatment or surgery on an animal . . . shall prepare a written record or computer record concerning the animals" including such facts as examination findings, test results, diagnosis, and treatment plan.²⁶⁴ However, a requirement for keeping records does not necessarily mean that the records will be kept at a level adequate to avoid problems. Regarding record keeping, Green believes the evidence suggests that "organizational laxity is rampant in the veterinary profession."²⁶⁵

²⁵⁸ *People v. Arroyo*, 777 N.Y.S.2d 836, 845 (N.Y. Crim. Ct. 2004).

²⁵⁹ *Id.* at 846.

²⁶⁰ *Martinez v. State*, 48 S.W.3d 273, 278 (Tex. App. 2001) (Lopez, A., concurring).

²⁶¹ See Coe et al., *Communication Study*, *supra* n. 231, at 1074 (discussing the optional nature of veterinarian procedures); Consumer Reports, *Is Pet Insurance Worth the Price?*, <http://www.consumerreports.org/pets/0307vet2.html> (July 2003) (accessed Nov. 20, 2010) (stating that only 1% of pet owners have pet insurance).

²⁶² Coe et al., *Monetary Aspects Study*, *supra* n. 208, at 1516.

²⁶³ AVMA, *AVMA Policy, Principles of Veterinary Medical Ethics of the AVMA*, <http://www.avma.org/issues/policy/ethics.asp> (accessed Nov. 20, 2010).

²⁶⁴ Minn. R9100.0800(4)(A)(5)–(8) (Westlaw current through Aug. 16, 2010).

²⁶⁵ Green, *supra* n. 44, at 190.

Keeping good and thorough medical records is mandated by law, good patient care, and professional ethics. However, keeping good records requires time on the part of the veterinarian, and that time translates into cost. As discussed above, facilities such as those accredited by AAHA mandate “that medical records be thorough and complete . . . [allowing for a] better understand[ing of the] pet’s medical history and how past health issues might be impacting the . . . current medical status,”²⁶⁶ a process that may be more expensive.²⁶⁷ Thus, once again, the client who seeks low-cost care and the veterinarian who provides that care will bear the financial brunt of the increased record keeping dictated by a fear of litigation. There is no question that raising the quality of veterinary record keeping in general is the ethical thing to do. However, the public must bear the increased costs of that record keeping.

Interestingly, one commentator suggests that poor record keeping may actually be of benefit to the veterinarian in litigation. She states that there is

an additional barrier to filing a claim against a veterinarian—the difficulty of proving causation under veterinary malpractice standards. The record-keeping requirements in most veterinary practices are far less exhaustive than in human health care settings, and as a result, the ability of an animal’s guardian to prove that a veterinarian’s particular act or omission actually caused the injury or death of the animal under their care is extremely difficult.²⁶⁸

State practice acts and administrative rules already mandate production of veterinary medical records that are thorough and demonstrate that a case was handled within the proper standard of care. However, the reality of the situation is that enforcement of these rules by official agencies is often hit or miss, or even close to lacking entirely.²⁶⁹ Increased threat of litigation might have the effect of increasing the quality of record keeping in at least some veterinary practices. This would tend to increase the quality of care, but would come at a financial cost to both the practice and the consumer.

E. Standardization, Specialization, and Consolidation

It seems probable that the threat of increased litigation on the veterinary medical field would have an effect in widely disseminating the standard of veterinary care similar to the effect that the threat of litigation subsequent to *Pike v. Honsinger* had in disseminating the standard of medical care. Currently the field of veterinary medicine bears many similarities to nineteenth century medicine, which was “hetero-

²⁶⁶ AAHA, *About AAHA*, *supra* n. 216.

²⁶⁷ *Checkbook*, *supra* n. 210, at 29.

²⁶⁸ Jayne De Young, *Toward a More Equitable Approach to Causation in Veterinary Malpractice Actions*, 16 *Hastings Women’s L.J.* 201, 203 (2005).

²⁶⁹ Green, *supra* n. 44, at 183.

generously practiced [and] locally focused.”²⁷⁰ There is a very wide variation in the approach to veterinary practice in the U.S. Practices range from low-cost vaccine, spay, and neuter clinics to mixed-animal practices in rural areas to state-of-the-art hospitals with lasers, MRIs, and most of the other advanced diagnostic and treatment modalities that are available at hospitals for human patients. Understandably, the types and qualities of care furnished by these disparate facilities may vary. There is some question about whether veterinarians should be held only to that degree of skill and learning possessed by veterinarians in the same locality—the “locality rule”—or whether they should be held to a more broad-based standard. Recently, however, the trend has been to replace a local standard with a national one.²⁷¹ Thus, an increase in the threat of litigation, coupled with a national standard of care, would almost certainly increase the pressure on veterinarians throughout the U.S. to standardize their care.

Pressure to standardize care would likely have a similar effect on the provision of veterinary specialty services as it did on the provision of human specialty services. This is especially true given the fact that

medical doctors are trained to treat only one species—the human; veterinarians must acquire a more diverse knowledge base and must accept that what may be “normal” for one species (e.g., a cat) may not be so “normal” for another species (e.g., a snake). Because a veterinarian is generally required to acquire a broad knowledge base about many types of animals, specialized knowledge about a particular type is necessarily sacrificed.²⁷²

Over the past century, the percentage of specialists in human medicine has risen to the point where currently 75% of physicians are board-certified in at least one specialty.²⁷³ In contrast, 11% of veterinarians are board certified in a specialty,²⁷⁴ of which over a third are certified in non-clinical specialties such as pathology, bacteriology, and toxicology.²⁷⁵ Thus, there are currently far fewer board-certified clinical specialists as a percentage of practicing veterinarians than there are of practicing physicians. A need to provide more referrals due to the standardization of care would tend to increase the number of specialists needed in veterinary medicine. This in turn would tend to increase amounts paid for care as specialists sought to recoup the time and money spent in the two to five years of additional education needed for advanced training.

Because specialty services are typically provided in large group practices or hospital settings, these sorts of practices would likely become more the norm than the exception. Currently, the average veteri-

²⁷⁰ Hogan, *supra* n. 64, at 1.

²⁷¹ De Young, *supra* n. 268, at 211.

²⁷² Nunalee & Weedon, *supra* n. 36, at 148.

²⁷³ Eichinger, *supra* n. 154, at 237–38.

²⁷⁴ *Id.* at 238.

²⁷⁵ See AVMA, *AVMA Membership Directory & Resource Manual* 209–91(57th ed., Am. Veterinary Med. Assn. 2008) (listing specialty boards and diplomates).

nary facility has 2.4 full time equivalent veterinarians.²⁷⁶ This would change as the percentage of large specialty practices increased in response to the demand for those services. As Nunalee and Weedon state, “[t]he simple sole proprietor or partnership will become a thing of the past, being replaced by such entities as professional associations, professional corporations or professional limited liability companies designed to minimize personal liability.”²⁷⁷

F. *Improvement of Care and Reduction of Errors*

According to Green, “the potential for such [noneconomic] compensation will reduce the number of unnecessary accidents—and actually improve the standards of veterinary care.”²⁷⁸ It is logical to believe that an increase in the number of referrals to board-certified specialists would improve the quality of care given to the pets that received that care. However, given the human medical experience, it is difficult to say how much effect an increase in litigation might have on improvement of care and reduction of errors in the practice of veterinary medicine in general. As stated above, there is a lack of empirical evidence that the threat of medical malpractice has significantly reduced medical errors.²⁷⁹ It is reasonable to assume that the same would prove true of the veterinary experience.

G. *Veterinarian Effects*

Veterinarians routinely fight hard for their patients’ lives, often under substantial economic and technological limitations. When a pet simply succumbs to the inevitable, and the pet owner nevertheless brings suit against the veterinarian, the doctors are left “feel[ing] victimized . . . [and] falsely accused.”²⁸⁰

The fear of litigation has had a profound effect on the people who practice or are considering human medicine as a career.²⁸¹ There is no logical reason why the same would not be true of the people who practice or are considering practicing veterinary medicine. In fact, there

²⁷⁶ AVMA, *Financial & Productivity Pulsepoints* 3 tbl. 1 (Erin Landeck ed., 4th ed., Am. Animal Hosp. Assn. 2006).

²⁷⁷ Nunalee & Weedon, *supra* n. 36, at 159.

²⁷⁸ Green, *supra* n. 44, at 249.

²⁷⁹ Sloan & Chepke, *supra* n. 10, at 3.

²⁸⁰ Eichinger, *supra* n. 154, at 260.

²⁸¹ See Common Good, *Fear of Litigation: The Impact on Medicine*, <http://commongood.org/healthcare-reading-cgpubs-polls-6.html> (April 22, 2002) (accessed Nov. 20, 2010) (“Concerns about liability are influencing medical decision-making on many levels.”); see also Beth Walton, City Pages, *Minnesota Ranks Second-Lowest in the Nation for Total Disciplinary Actions Against Doctors*, <http://www.citypages.com/2008-05-14/feature/minnesota-ranks-second-lowest-in-the-nation-for-total-disciplinary-actions-against-doctors/> (May 14, 2008) (accessed Nov. 20, 2010) (providing that increased litigation has caused a decline in the number of medical students going into complex specialties).

are many differences between human medicine and veterinary medicine that have the potential to severely exacerbate this issue.

One of the major differences is the pay scale for veterinarians and their support staff. Compared to human medicine, salaries are significantly lower. The median salary for veterinarians is \$79,050 per year.²⁸² The median salaries of human medical doctors vary widely by specialty; however, a good comparison for veterinarians might be pediatricians, who earn a median salary of \$161,410.²⁸³ Arguably even worse for the provision of care and reduction of errors, certified veterinary technicians earn an average salary of \$28,900²⁸⁴ while their counterparts in human medicine, registered nurses, earn an average salary of \$66,530.²⁸⁵ Educational requirements and student debt for these groups tend to be similar.²⁸⁶

The latest studies reflect a growing crisis in the field of veterinary medicine involving a mismatch between veterinary student debt and starting salaries. Currently, the average starting salary for veterinarians entering private clinical practice is \$65,185.²⁸⁷ The average educa-

²⁸² Bureau of Lab. Statistics, *Occupational Outlook Handbook, 2010–11 Edition, Veterinarians, Earnings*, <http://www.bls.gov/oco/ocos076.htm#earnings> (accessed Nov. 20, 2010) [hereinafter Bureau of Lab. Statistics, *Veterinarians*].

²⁸³ Bureau of Lab. Statistics, *Occupational Employment and Wages, May 2009: 29-1065 Pediatricians, General*, [http://www.bls.gov/oes/current/oes291065.htm#\(2\)](http://www.bls.gov/oes/current/oes291065.htm#(2)) (accessed Nov. 20, 2010).

²⁸⁴ Bureau of Lab. Statistics, *Occupational Outlook Handbook, 2010–11 Edition, Veterinary Technologists and Technicians, Earnings*, <http://www.bls.gov/oco/ocos183.htm> (accessed Dec. 2, 2010) [hereinafter Bureau of Lab. Statistics, *Veterinary Technologists*].

²⁸⁵ Bureau of Lab. Statistics, *Occupational Employment and Wages, May 2009: 29-1111 Registered Nurses*, <http://www.bls.gov/oes/current/oes291111.htm#> (accessed Dec. 2, 2010).

²⁸⁶ See Bureau of Lab. Statistics, *Occupational Outlook Handbook, 2010–11 Edition, Physicians and Surgeons*, <http://www.bls.gov/oco/ocos074.htm> (accessed Nov. 20, 2010) (providing that physicians, including pediatricians, must attend a minimum of seven years of formal education); Bureau of Lab. Statistics, *Veterinarians, supra* n. 282, at <http://www.bls.gov/oco/ocos076.htm#training> (providing that most veterinarians obtain a bachelor's degree and complete a four-year degree from a college of veterinary medicine); Medscape General Medicine, *Is Medical Student Choice of a Primary Care Residency Influenced by Debt?*, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1868367/> (Oct. 24, 2006) (accessed Nov. 20, 2010) (providing that the average medical student accumulates more than \$120,000 in debt); *Employment, Starting Salaries, and Educational Indebtedness of Year-2009 Graduates of US Veterinary Medical Colleges*, 235 J. Am. Veterinary Med. Assn. 523, 525 (2009) (providing that the average debt for veterinary students is \$129,976) [hereinafter *Veterinary Graduates*]; Bureau of Lab. Statistics, *Occupational Outlook Handbook, 2010–11 Edition, Registered Nurses*, <http://www.bls.gov/oco/ocos083.htm> (accessed Nov. 20, 2010) (providing that registered nurses complete two, three, or four-year programs); Bureau of Lab. Statistics, *Veterinary Technologists, supra* n. 284 (providing that veterinary technicians may complete either two or four-year programs); Costhelper, *Nursing School Cost*, <http://www.costhelper.com/cost/education/nursing-school.html> (updated Jan. 2009) (accessed Nov. 20, 2010) (providing the costs of various nursing programs); VeterinarySchools.com, *Veterinary Technologists and Technicians*, <http://www.veterinaryschools.com/about-veterinary-technologists-and-technicians.html> (Apr. 25, 2005) (accessed Oct. 3, 2010) (providing the costs of various veterinary technology programs).

²⁸⁷ *Veterinary Graduates, supra* n. 286, at 525.

tional debt of graduating veterinary students is \$129,976,²⁸⁸ with over 11% of students having in excess of \$200,000 in educational debt.²⁸⁹ Tuition for veterinary school is increasing at a faster rate than starting salaries,²⁹⁰ leaving some students looking at debt repayment periods of over 20 years.²⁹¹ One economist remarked that “[i]f the cost-earnings ratio fails to soon balance, students simply won’t be able to afford a career in veterinary medicine.”²⁹²

Even without the threat of increased litigation, the bare economic realities of veterinary school and subsequent practice are already beginning to take their toll. According to James Wilson, D.V.M., J.D., adjunct professor at the University of Pennsylvania School of Veterinary Medicine, these financial issues are already having an adverse effect on the quality of applicants.²⁹³ It seems logical to conclude that knowledge that they may be subject to the same types of litigation as their human medical counterparts will take an additional toll on those considering a career in veterinary medicine. As Eichinger states,

[e]ven more ominous long-term for veterinary medicine and pet owners, increased malpractice exposure may result in fewer bright, young students willing to undertake four rigorous, demanding and expensive years of professional education. How many of the best and brightest will be willing to make the financial and personal sacrifices necessary to become veterinarians, only to then subject themselves to the same “lawsuit lottery” system that their physician counterparts already undergo, albeit for much higher pay?²⁹⁴

Admission to veterinary school is highly competitive. For example, statistics on the 2010 entering class at the University of Minnesota show that 1,033 prospective students applied for the 100 student seats in that class.²⁹⁵ Accepted students had a mean grade point average of 3.58/4.00.²⁹⁶ Clearly, these accepted students would be competitive for seats in other types of professional schools, such as medical or dental school. Starting salaries for medical doctors and dentists are significantly higher than those for veterinarians, while the length of schooling and debt loads are similar.²⁹⁷ This suggests that the choice to

²⁸⁸ *Id.*

²⁸⁹ *Id.*

²⁹⁰ *Drowning in Debt*, 50 *Veterinary Econ.* 20, 23 (Aug. 2009).

²⁹¹ *Id.* at 25.

²⁹² Jennifer Fiala, *Crisis Looms as Debt-to-Salary Statistics Paint Bleak Outlook for Veterinary Medicine’s Future, Experts Say*, *DVM Newsmagazine* 1, 19 (March 2008).

²⁹³ *Id.*

²⁹⁴ Eichinger, *supra* n. 154, at 273.

²⁹⁵ U. of Minn. Educ. & Student Serv., *Profile of Successful Applicants*, <http://www.cvm.umn.edu/education/prospective/Profile/home.html> (updated June 7, 2010) (accessed Nov. 20, 2010).

²⁹⁶ *Id.*

²⁹⁷ See Bureau of Lab. Statistics, *Occupational and Employment Wages, May 2009: Pediatricians, General*, <http://www.bls.gov/oes/current/oes291065.htm> (updated May 14, 2010) (accessed Nov. 20, 2010) (showing the median annual wage for pediatricians (general) is \$152,240 as of May 2009); Bureau of Lab. Statistics, *Occupational and Employ-*

attend veterinary school is often not one of economics, but one of emotion. People enter the field of veterinary medicine because they want to “work with and care for animals.”²⁹⁸

If the practice of veterinary medicine follows the practice of human medicine into lawsuits and litigation, veterinary training may lose its attraction for many of its best applicants. This will occur for two reasons. The first is economic. With starting salaries often barely enough to cover living expenses and student loans, any upward pressure on the costs of doing business may lead to pay scales that are untenable for new veterinarians. To preserve the current pay levels, veterinarians may have to work even longer hours than they do now, leading to decreased quality of life. The second, and perhaps more important reason, is one of emotion. The decision to go to veterinary school is often an emotional one. The vast majority of students choose veterinary school because they want to help people and their pets. An increasingly adversarial relationship with their clients will erode the very reason that these students wanted to be veterinarians in the first place. This will lead to a decrease in the quality of veterinary school applicants as the ones that can move to other more remunerative professions do so.

Even Green, while seeming to dismiss its importance, cites the “fear” that drives veterinarians to oppose noneconomic damage awards: “fear of limitless liability, of replicating the human medical malpractice ‘crisis,’ of inviting frivolous lawsuits; or even of being forced out of business.”²⁹⁹ Unfortunately, the effects of fear—whether justified or not—can be profound. Fear takes an emotional, psychological, and behavioral toll on those experiencing it.

ment Wages, May 2009: Dentists, General, <http://www.bls.gov/oes/current/oes291021.htm> (updated May 14, 2010) (accessed Nov. 20, 2010 (showing the median annual wage for dentists (general) is \$142,090 as of May 2009); Bureau of Lab. Statistics, *Occupational and Employment Wages, May 2009: Veterinarians*, <http://www.bls.gov/oes/current/oes291131.htm> (updated May 14, 2010) (accessed Nov. 20, 2010 (showing the median annual wage for veterinarians is \$80,510 as of May 2009); Education-Portal.com, Dentist Education Requirements and Career Information, http://education-portal.com/dentist_education_requirements.html (accessed Nov. 20, 2010) (providing that dentists must complete a bachelor’s degree and four year dental program); Bureau of Lab. Statistics, *Veterinarians*, *supra* n. 282, at <http://www.bls.gov/oco/ocos076.htm#training> (providing that most veterinarians complete a bachelor’s degree and a four-year degree from a college of veterinary medicine); Education-Portal.com, Requirements to Become a Doctor in the U.S., http://education-portal.com/requirements_to_become_a_doctor.html (accessed Nov. 20, 2010) (providing that doctors generally complete a bachelor’s degree and four years of medical school); *Veterinary Graduates*, *supra* n. 286 (providing that the average debt for veterinary students is \$129,976); Medscape Gen. Medicine, *supra* n. 286 (providing that the average medical student accumulates more than \$120,000 in debt); Am. Dental Assn., Financial Planning Issues for Dental Students I, http://www.ada.org/sections/educationAndCareers/pdfs/finplan10_final.pdf (accessed Nov. 20, 2010) (stating that “[o]ver 77% of graduates have more than \$100,000 in debt while almost 50% have more than \$175,000.”).

²⁹⁸ Coe et al., *Monetary Aspects Study*, *supra* n. 208, at 1516.

²⁹⁹ Green, *supra* n. 44, at 216.

VII. POTENTIAL ALTERNATIVES TO LITIGATION FOR VETERINARY MALPRACTICE

Regulatory bodies, in the form of boards of veterinary medicine, are charged with the task of addressing veterinary malpractice. Whether they are now, or could be, adequate for that task is an open question. Green believes that the penalties assessed by state licensing boards are

often too lenient to meaningfully reprimand veterinarians who cause negligent or intentional animal harm. Furthermore, while these state and professional veterinary licensing boards do provide avenues for individual citizens to file complaints alleging negligence or malpractice, they *do not* allow individual parties to personally recover *any* damages or economic relief from the process.³⁰⁰

He adds that “years of disciplinary statistics clearly demonstrate that these regulatory bodies rarely take serious action in instances of negligence or professional incompetence—essentially eliminating the likelihood of any meaningful enforcement of the veterinary standard of care.”³⁰¹ Although this may be true, an increase in the vigilance of such boards may be an option in addressing the problem of veterinary malpractice.

The Model Veterinary Practice Act is promulgated by the AVMA.³⁰² It is “intended to serve as a model set of guiding principles” for legislatures in their enactment of state veterinary practice acts.³⁰³ Section 14 of the Model Act states that “the Board . . . may . . . revoke, suspend, or limit for a certain time the license of, or otherwise discipline, any licensed veterinarian for . . . incompetence, gross negligence, or other malpractice in the practice of veterinary medicine.”³⁰⁴ This gives veterinary medical boards broad powers to deal with veterinarians who have committed malpractice. The threat of losing a license to practice is likely to be a powerful incentive to practice within the standard of care. Thus, an effective board of veterinary medicine may have as much or more power as the threat of litigation on enforcing quality veterinary care.

Boards of veterinary medicine can also help ensure quality care by requiring veterinarians to pursue continuing education. “The primary purpose of continuing veterinary education is to assure the consumer of an optimal quality of veterinary care by requiring veterinarians to attend educational or training programs designed to advance their professional skills, knowledge, and obligations.”³⁰⁵ Specific requirements as to the type and number of hours of continuing education vary by

³⁰⁰ *Id.* at 183 (emphasis original).

³⁰¹ *Id.*

³⁰² Model Veterinary Prac. Act (Am. Veterinary Med. Assn. 2007) (available at <http://www.avma.org/issues/policy/mvpa.asp>) (accessed Nov. 20, 2010)).

³⁰³ *Id.*

³⁰⁴ *Id.* at § 14.

³⁰⁵ Minn. R. 9100.1000(2) (2007).

state.³⁰⁶ Failure to complete required continuing education is grounds for disciplinary action by a board of veterinary medicine.³⁰⁷

Alternative dispute resolution approaches such as arbitration and mediation have also been suggested as viable alternatives to litigation in the veterinary malpractice arena.³⁰⁸ Whether these approaches would have the same effect on veterinary medicine as litigation is unknown. However, any quasi-judicial approach resulting in substantial damages brings with it the possibility of causing similar effects as litigation.

VIII. THE VALUE OF THE HUMAN-ANIMAL BOND

Several commentators have made much of the apparent disconnect between the celebration of the human-animal bond by the veterinary community on the one hand and the refusal by at least a portion of the veterinary community to endorse noneconomic damages on the other hand. One commentator forcefully states that “because veterinarians make their living from the relationship between human guardians and their companion animals, it is morally bankrupt for veterinarians to insist that companion animals be valued as mere property.”³⁰⁹

Green believes that the veterinary celebration of the human-animal bond is at least partly motivated by financial considerations. He states, “[i]t is crucial for all to understand that veterinarians are not mere bystander beneficiaries of pet owners’ increased economic valuation of companion animals, but rather have spent decades actively developing this bond as a means of professional survival.”³¹⁰ This has resulted in the veterinary community gaining a “wealth of benefits . . . from society’s increased valuation of companion animals.”³¹¹ He goes on to state that “opposition [to noneconomic benefits awards] has jeopardized the very credibility of the veterinary profession and left it exposed to charges of flat-out hypocrisy.”³¹²

This is a very compelling argument. However, it is not necessarily reflective of reality. Rather than endorsing the human-animal bond in a cynical exploitation of their clients, it is very possible that most vet-

³⁰⁶ See e.g. Or. Veterinary Med. Assn., Continuing Education Rules & Guidelines, <http://oregonvma.org/continuing-education-rules> (accessed Nov. 20, 2010) (showing that the state of Oregon requires thirty clock hours of continuing education every odd-numbered year and fifteen hours every even-numbered year); 888 Ind. Admin. Code 1.1-10-1 (2009) (available at http://www.in.gov/pla/files/IBVME.2009_EDITION.pdf (accessed Nov. 20, 2010)) (showing that the state of Indiana requires forty clock hours of continuing education every odd-numbered year and sixteen clock hours every even-numbered year).

³⁰⁷ Minn. R. 9100.1000(8)(C)(1) (2007).

³⁰⁸ Rebecca J. Huss, *Valuation in Veterinary Malpractice*, 35 Loy. U. Chi. L.J. 479, 548 (2004).

³⁰⁹ Byszewski, *supra* n. 33, at 230.

³¹⁰ Green, *supra* n. 44, at 212–13.

³¹¹ *Id.* at 215.

³¹² *Id.*

er veterinarians actually *believe* in the importance of that bond. It is possible that the majority of men and women who go into companion animal medicine as a career do so because they find the importance of the human-animal bond in their own lives so compelling. As discussed above, many individuals enter the field of veterinary medicine for emotional rather than financial reasons. Thus, it is reasonable to postulate that one of the major emotional factors influencing people to enter the field of veterinary medicine is their love for the human-animal bond. Fettman and Rollin posit that the human-animal bond can be the “direct object of moral attention for interactions among the owner, patient, and veterinarian.”³¹³ In this case, the veterinarian’s duty is directly to the bond rather than to the owner or the patient as an individual.³¹⁴

Similarly, it is very possible that the reason that at least some veterinarians reject the concept of noneconomic damages in veterinary medicine is not that they do not value animals beyond their “economic” value, but that they believe that noneconomic damages will negatively impact their duty to the human-animal bond and their ability to give care to their patients. Obviously, no one knows whether noneconomic damages will have a negative effect on the delivery of veterinary care. However, as discussed above, there is objective evidence that this may be true.

Thus, rather than being “morally bankrupt” hypocrites, it is probable that veterinarians are acting rationally and ethically in following their best predictions as to the effect noneconomic damages will have on their ability to provide care to their patients. Any reduction in care to patients will necessarily have a negative effect on what many veterinarians value most highly—the human-animal bond.

IX. WHY IS HUMAN MEDICINE SO EXPENSIVE IN THE UNITED STATES?

In 2002, the U.S. spent \$5,267 per person on health care.³¹⁵ By contrast, Switzerland, the second most expensive country for health care, spent only \$3,445 per capita.³¹⁶ Other developed countries such as the United Kingdom spent as little as 41% per capita of the amount spent in the U.S.³¹⁷ Thus,

[c]ompared to other leading nations, the U.S. spends vastly more per head on healthcare, while often getting worse outcomes. Despite these high and

³¹³ Martin J. Fettman & Bernard E. Rollin, *Modern Elements of Informed Consent for General Veterinary Practitioners*, 221 J. Am. Veterinary Med. Assn. 1386, 1389 (2002).

³¹⁴ *Id.*

³¹⁵ Thomas Bodenheimer, *High and Rising Health Care Costs. Part 1: Seeking an Explanation*, 142 *Annals Internal Med.* 847, 847 (2005).

³¹⁶ *Id.*

³¹⁷ *Id.*

rising costs . . . the U.S. lags behind other countries on measures such as life expectancy at birth . . . and infant mortality.³¹⁸

Opinions as to the origin of the expense of human medicine in the U.S. are many and varied. They include such factors as technology,³¹⁹ insurance,³²⁰ defensive medicine,³²¹ malpractice litigation,³²² administrative costs,³²³ and many others. In all likelihood, the problem is multifactorial and not attributable to any single or small group of causes.

Whatever the origins of the high cost of human health care in the U.S., the fact that human health care is so expensive ought to at least induce some caution in those seeking to create a system in which veterinary medicine becomes more like its human counterpart. Currently, veterinary procedures cost less than 10% of the cost of similar procedures performed on humans.³²⁴ Because both types of procedures are performed by professionals with similar educational backgrounds using similar equipment, instruments, and supplies, one has to ask why there is a marked price difference between the two procedures. To the extent that increased litigation has contributed to the increases in human health care costs, litigation has the potential to have a similar impact on the cost of veterinary medicine.

X. CONCLUSION

The imposition of increased legal liability on the providers of veterinary care is likely to have significant and far-reaching effects. It will affect veterinarians and their staffs, pet owners and their four-legged family members, and society as a whole. Whether these effects are desirable depends on many public policy considerations.

Ironically, it may be the highest quality care facilities that are most often sued. These facilities tend to have clients with high expectations—otherwise, why would clients choose to take their pets to veterinarians offering such specialized services as board-certified specialists, MRIs, and advanced treatment options? These types of facilities tend also to charge fees that are significantly higher than lower quality practices. They also tend to attract clients who value their pets highly. This combination is likely to result in disgruntled clients if their pets' treatment does not go as they had expected. This, combined with the possibility of substantial noneconomic damage awards, would put these high-quality care facilities at a significant risk of lawsuits.

³¹⁸ Peter Aldhous & Jim Giles, *Insight: Money Alone Won't Cure What's Ailing America's Healthcare*, 203 *New Scientist* 7 (Aug. 1, 2009).

³¹⁹ Bodenheimer, *supra* n. 315, at 848.

³²⁰ Howard Gleckman, *Business Week*, *So That's Why It's So Expensive* 65 (Aug. 14, 2006).

³²¹ Reynolds et al., *supra* n. 109, at 2776.

³²² Mello & Studdert, *supra* n. 78, at 13.

³²³ Bodenheimer, *supra* n. 315, at 848.

³²⁴ Eichinger, *supra* n. 154, at 237.

The lower price, lower quality practice would tend to have clients with lower expectations, who place less value on their pets and who have spent less money on their pets' treatment. These factors would tend to insulate the lower-quality practice from being the target of lawsuits. This result, if it proves true, would contradict many of the rationales for malpractice litigation—veterinarians practicing at a high level would tend to be sued more often than those practicing at a lower level of care.

In spite of this, it is likely that the facilities that would most have to change their way of doing business would be the lower-cost facilities that make their money on quick procedures and short appointment times. These facilities would need more extensive record keeping, additional client communication, and other time-consuming actions. This would certainly benefit their patients. The question is, would the increased cost of these acts be acceptable to the owners of these pets? Society needs to decide what is more valuable: a consistent standard of care for all veterinary patients, or giving pet owners the option to choose a lower cost, lower quality service. Given the number of people who take their pets to low cost clinics, it seems that they are voting with their feet (or pocketbooks). Will those same people be willing to pay more for their pets' care for the option of suing their veterinarian if something goes wrong with that care? Do they simply fail to understand that the price savings they are seeking must come with a reduction in services? The public cannot have it both ways. There is essentially no way for a veterinarian to provide high quality services at a low cost price. It is especially unfair for clients to require that their veterinarian provide low-cost services and then have the ability to sue for malpractice when those services turn out to be suboptimal.

Another question to be asked is, how is the standard of care determined? Is it based on what the most demanding clients want and highest quality hospitals provide? If so, what is done with clients who want less? Can they opt for treatments below this standard of care? If so, are there acts that are so far below the standard of care that clients cannot opt for them and veterinarians cannot offer or perform them? These are all very important questions to answer before the true effect of increased malpractice litigation on veterinary medicine can be assessed.

As the court in *McMahon v. Craig* pointed out, granting noneconomic damages for veterinary malpractice would be problematic in that "it would be difficult to cogently identify the class of companion animals because the human capacity to form an emotional bond extends to an enormous array of living creatures."³²⁵ Professor Cupp also fears that "the movement to treat pets more like humans under the law could lead to an avalanche of far-fetched animal rights lawsuits, such as claims on behalf of beef cattle headed for slaughter or monkeys used in medical research."³²⁶ The use of the potential for awards of

³²⁵ *McMahon*, 176 Cal. App. 4th at 1515.

³²⁶ Parker, *supra* n. 158.

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noneconomic damages in litigation by the animal rights community is a likely extension of their activities. Again, it is a matter of public policy as to whether or not such types of litigation should be encouraged by a change in the legal definition of animals.

Once increased litigation regarding veterinary malpractice is unleashed, it is unlikely that there will be any going back. If this happens, the changes to society are likely to be profound. As one commentator predicts, “[u]ltimately . . . the business of veterinary medicine will be virtually identical to the business of human medicine.”³²⁷ We as a society need to think long and hard as to whether this is an outcome we desire.

³²⁷ Nunalee & Weedon, *supra* n. 36, at 160.

