

# Virtual Mentor

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## Op-ed

### Is "no-fault" the cure for the medical liability crisis?

Responses by David E. Seubert, MD, JD, and by Laurie T. Cohen, JD, and Jason M. LaFlam, JD

#### Response 1

by David E. Seubert, MD, JD

Patients who suffer an adverse health care outcome often assume that, but for the negligence of their treating physician, their condition would be different. Such patients then often engage a plaintiff attorney and begin a long journey down the tort pathway to seek compensation. This process is adversarial and has many inconsistencies. Many patients are seeking compensation for outcomes that clearly were out of the hands of the treating physicians and health care team. Nonetheless, clever lawyering skills can distort the picture and, when the case is presented to a lay jury, a windfall award can be granted. But who really wins here? If the patient gains an award, it is usually years after the adverse event, and the award is reduced by a large percentage that covers the attorney's fees and expenditures associated with the trial.

The greater theme that must emerge is the effect of this adversarial process on society. The current process promotes the legal profession's view of physicians as "conspirators of silence." This conception was born from the fact that physicians served with civil notice of a pending medical malpractice case against them are informed by their attorneys to keep their mouths shut and not to discuss the case with anyone. This often isolates the physician and leads to responses such as depression and anger [1, 2]. But what if the physician could speak at the time of the event and offer insight and interpretation of what happened, prior to being deposed or appearing in court years later? Clearly this more forthright and contemporaneous approach offers many benefits for society.

A no-fault system of compensation for medical injury similar to the workers' compensation and automobile insurance models may be the answer to the medical malpractice crisis omnipresent in the United States today. Allowing physicians to come forward when an error occurs and join forces with their patient(s) and the hospital system could improve the entire network of health care. The current conspiracy of silence carries great risks for society. Suppose the error that has harmed a patient lies in a faulty system and has potential to do much more damage? Silence and lack of investigation of the problem can have greatly deleterious consequences.

A no-fault system encourages health care professionals to identify the system malfunction and take a proactive approach to fixing it. At the same time, where a patient has suffered harm, the no-fault system must assure appropriate compensation. Such an approach accomplishes two goals: first the patient is compensated for the injury, and, secondly, society's health care is upgraded and enhanced by fixing an error in the system. Such an error may in fact be a physician with a deficit. The no-fault process can identify this deficit and allow for physician retraining and rehabilitation.

The Swedish health care system has a 29-year-old progressive approach that is quite simple. This system encourages the networking of the patients and their treating physicians to cooperate in filing an adjudication claim to a panel for review. The panel then asks three questions, the first of which is: Was the injury the result of the treatment rendered [3, 4]? The process only proceeds if the answer to this question is "yes." The next two questions ask whether the treatment in question was medically justified and whether the outcome was unavoidable. If the answer to either of these questions is "yes," the patient is not eligible for compensation but does have the right to appeal the decision. If the answer to both questions is "no," the process continues. This collaboration between patient and physician must surely be healthier and more beneficial for society than our current adversarial approach with torts.

Several important questions spring to mind. What will be the impetus for such a change if it has not already occurred? Will the medical malpractice crisis have to get worse? Will more physicians have to stop practicing their specialty and more patients go without needed physicians? We will have to convince both physicians and attorneys that the no-fault system is the better model. Many physicians will fear the conversion since it is so ingrained in us that admitting a mistake equals liability. Attorneys will argue that this system in a sense partially abolishes the patient's right to a "day in court" in the civil arena. Finally, who will pay for this? Currently, medical malpractice premiums cover awards from settlements and jury decisions. A no-fault system would require a much different framework, with either the government or a physician-hospital model or a combination of the two responsible for compensation.

Critics of a no-fault system argue that it would be much more expensive for society. But Studdert et al. [3] did not find this to be the case when comparing the current malpractice systems in Utah and Colorado to a proposed no-fault system. While this model did show a slightly increased cost over the malpractice model, the no-fault model was more effective at getting the compensation into the proverbial "right hands." Clearly, it is much more beneficial for the patient and for society to have the compensation given mostly to the patient rather than to have a large percentage drift to the plaintiff attorney.

Finally, how do we teach our medical students and residents to accept the no-fault approach? Or even more fundamentally, are we equipped and prepared to do this at present? There is no doubt that our trainees would buy into this approach. Students

and residents are bombarded with stories of malpractice horrors. Many residents become victims to malpractice claims during the process of their training. But are we as teachers and mentors ready to abandon the current system as a profession and demand change? This is clearly the first step in the teaching process for our students and residents. We have a duty to our trainees to fix the system by adopting a no-fault approach that is progressive, nonadversarial, open and honest, and always in the interest of quality improvement. If we could instill this idea in our trainees, our health care system would be better, safer and stronger for our entire society.

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## Response 2

by Laurie T. Cohen, JD, and Jason M. LaFlam, JD

The present medical liability system, while not flawless, is efficient at adjudicating and paying those claims that have merit and at identifying and rejecting those that do not [1]. Even so, many pundits claim that the medical liability system in the United States is hopelessly broken and should be replaced by a no-fault system similar to that of Sweden or New Zealand. Central to these claims is the belief that the current system, unlike a no-fault system, dissuades physicians from being open and honest with patients and other professionals about medical errors, thereby hampering efforts to reduce errors and improve the quality of medical care. Adopting a no-fault system, however, would present many new challenges and may exacerbate some of the problems that advocates claim it would fix. Furthermore, enhancing the identification and disclosure of real or potential errors can be accomplished without replacing the current adjudicatory system.

The concept of a no-fault liability system, as opposed to the current negligence-based system, is not a new one. Workers' compensation systems have replaced the tort-based claims system for employer negligence in the workplace throughout the United States, and automobile insurance with no-fault clauses operates in several states. Moreover, Florida and Virginia have both instituted limited no-fault systems to address claims for birth-related neurological impairments in newborns. While such systems come with promises of simplification and cost containment, seldom has this been the overall result.

In New York, for example, the workers' compensation system, like the current medical liability system, is a source of continual debate about the cost of insurance premiums and the overall adequacy of the benefits paid to injured individuals. Nationally, workers' compensation payments by employers are estimated to have risen from \$2 billion in 1960 to nearly \$35 billion in 1985 and to \$62 billion in 1992 [2]. At the urging of employers, benefits have been reduced and other actions have been taken to contain costs. As a result, the workers' compensation payments by employers nationally were estimated to be \$63.9 billion in 2001 [3]. But this slower rate of increase has not lasted; high payments have employers once again clamoring for relief, and programs are once again re-examining worker benefits [4].

#### **Additional costs under no-fault: the international experience**

Costs will probably rise under a no-fault medical liability system if the New Zealand and Sweden experiences are valid measures. Both countries are often cited as examples to emulate. Yet both have implemented a series of changes throughout the lifetime of their no-fault systems in the quest for cost containment [5]. The basis for the additional costs associated with these programs is the inherent increase in eligibility for benefits that occurs when the negligence system's requirement to prove fault is eliminated. Therefore, to contain costs, these countries have found themselves restricting eligibility and benefit levels [6]. Moreover, in a study applying a Swedish model to the states of Utah and Colorado, it was estimated that use of the Swedish approach would lead to higher direct costs than the negligence approach [7]. The total cost would be higher even though the study presumed that the program would be a secondary payer, meaning private insurance and government programs would first pick up the tab for medical care under the system.

In addition to the potential rise in costs associated with increased eligibility under a no-fault medical liability system, real limitations may be placed on a wronged individual's current rights. While a no-fault system expects to compensate more individuals, there is a real question as to whether such compensation would be commensurate with the injury actually suffered. As exemplified by current workers' compensation programs, government cost-containment goals frequently cause limitations on compensation levels. Furthermore, no-fault programs often place limitations on recoveries for noneconomic damages such as pain and suffering. Switching to a no-fault system, therefore, may risk providing compensation to individuals who are considered "injured" despite receiving an appropriate level of

care, while those individuals severely injured through the negligent actions of their physicians are undercompensated.

The present medical liability system is meant not only to compensate individuals for the wrong committed against them, but to help deter future wrongful acts by the responsible party [8]. In contrast, a no-fault medical liability system is inherently centered on compensating eligible individuals and is not necessarily concerned with acting as a deterrent or with imposing a penalty on a responsible party. Failure to place fault on the responsible individuals may have implications for the quality of medical care. Many proponents of a no-fault system argue that the deterrence factor has been mitigated because payments are made by medical malpractice insurers and not by the negligent physicians themselves, but this arrangement does not eliminate the nonmonetary costs of medical malpractice litigation. "[A] malpractice suit challenges the professional performance, reputation, and identity of a doctor or nurse or other health care provider" [9], not to mention the tremendous impact on that professional's time. For these reasons, physicians are motivated by the current system to act with due care.

One of the best examples of the current system's ability to prompt change may be seen in the experience of the specialty of anesthesiology. As a result of the medical malpractice insurance crisis facing anesthesiologists in the United States during the 1980s, the profession adopted uniform practices and procedures that greatly diminished medical errors and subsequently reduced the insurance premiums anesthesiologists pay [10].

There are certainly actions which could be taken to improve the current system. One approach that has shown positive results involves efforts to encourage physicians to acknowledge their mistakes and apologize to patients and families. In Colorado, for example, certain statements made by a health professional to the patient or the patient's family or representative concerning medical errors are inadmissible as evidence of liability in civil actions or arbitration proceedings [11]. Anecdotal evidence from Colorado and several health systems have shown that the so-called "I'm sorry" approach results in fewer lawsuits and reduced costs when resolving claims.

The extent of the impact of these communication efforts will depend largely on the actions of medical professionals. If they choose to incorporate disclosure of medical errors into their routine practice, the overall health care delivery system, including their individual patients, may benefit immensely. It is often a professional's failure to be forthright about errors and medical outcomes that prompts a civil action [12]. While not precisely determinable, the decrease in civil actions attributable to a simple apology has been estimated to be in the range of 10 to 30 percent [13]. Forthright reporting of errors also increases the potential that corrective measures will be taken to rectify the cause of the error, thus decreasing the potential for repeat errors. Finally, to the extent that compensation is still required after apology, the

process should be less adversarial, decreasing the administrative costs to the medical liability system.

In conclusion, while the present system is not flawless, a no-fault medical liability system is not the right answer. Such a system may promise cost containment and compensation to a larger group of individuals, but it inevitably fails to deliver those savings, or it does so at the expense of those suffering from the negligent conduct. Reforms to the existing system, such as fostering increased communication of errors, limiting the use of juries for determinations of fault but not for determination of damages or using neutral medical experts, may prove more advantageous to both patients and physicians.

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