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HOW CAN ASIAN COUNTRIES DEAL WITH MEDICAL LIABILITY AND PATIENT COMPENSATION

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Abstract

All around the world countries are trying to find a solution to deal with medical liability and patient compensation. Some legal orders have opted for a no-fault system, in which the patient is compensated once certain requisites are fulfilled, which are apparently less demanding than the ones required for granting compensation in light of tort liability. However, many of the advantages of the no-fault model are actually illusory. In addition, this model is not suitable for most legal orders and certainly not for Asian countries, as the present paper intends to demonstrate. Conversely, we sustain the maintenance of the traditional model based on negligence (from the doctor or from the institution), but modified and complemented by some notes typical of the no-fault system and by the so-called alternative dispute resolution mechanisms.

Keywords

Accountability, Alternative Dispute Resolution, Compensation, Health Courts, Liability, Medical Malpractice, Negligence, No-Fault, Patient Safety

1. Introduction: The Classical Problem of Medical Liability

When the patient suffers an injury during a medical procedure the victim and his family turn to the legal order looking for the fulfillment of certain aspirations. Traditionally the plaintiff's pretensions were, first and foremost, an economic compensation, both for patrimonial and moral damages; and secondly, a reasonable punishment for the offender, usually provided by criminal law. But in the last couple of years new pretensions have raised, even assuming the leading edge on the plaintiff's goals: on the one hand, an explanation regarding the unsuccessful outcome and, eventually, and apologize or any other sympathetic gesture; on the other hand, the doctor's (or the institution's) acknowledgment that a mistake was made and, consequently, the guarantee that adequate measures will be implemented in order to avoid new injuries in the future.

However, the current model to deal with medical malpractice and patient's injuries - the model based on negligence, i.e., the use of traditional tort law to medical malpractice[1]– can only satisfy the first two aspirations and has proved to be incapable of providing explanations and apologies or of promoting patient's safety. The reason for this failure may be that this model is based on the classical canons of juridical liability evaluated in court by judges, frequently totally unaware of the particularities of medicine. Therefore, the failure of tort law can be explained, on the one hand, by inadequacy of tort law to deal with the specificities of medicine; on the other hand, by the absence of an expert evaluation, since court judges are not suited to evaluate complex medical cases. Both these handicaps can conduce to unfair solutions.

To this it may be added the limited nature of its goals, basically restricted to pointing the finger to someone, disregarding the fact that many times it is not possible to identify the "guilty one". In fact, most of the injuries are due to system failures, as the Institute of Medicine (IOM) underlined it more than a decade ago (IOM, 2000; Leape & Berwick, 2005).

In light of the inadequacies pointed out to the negligence model, the no-fault model seems a very appealing solution to deal with injuries suffered during a medical treatment. Consequently, this model has known increased support and it is being adopted in several legal orders, even if just for particular situations. Indeed, it is already in practice in the Nordic countries (Eyben, 2001; Johansson, 2010; Kachalia et al., 2008; Ulf beck et al., 2013) and in New Zealand (Bogdan, 2011; Bismarck et al., 2006; Bismarck & Paterson, 2006; Malcolm &

Barnett, 2007), and also in other legal systems but in a more limited way, as in some US states (Coppolo, 2003) and in France (OECD, 2006). Likewise, in Asia the no-fault system as been implemented for particular scenarios, such as in Japan for severe cerebral palsy caused during childbirth delivery accidents (Akimoto, 2011). Recently China also has shown interest in a no-fault compensation scheme for vaccine injuries (Gourley et al., 2009).

Nevertheless, some of its more seducing traits hide insurmountable fragilities, as this study will demonstrate. Furthermore, even if it were a perfect model, the fact it that the requirements demanded for its successful functioning (requisites of juridical, economic and sociological nature) are so challenging that they can only be achieved in very particular legal orders (The Canadian Medical Protection Association, 2006).

2. Brief Characterization of the No-Fault Model

The main characteristic of the no-fault model is its focus in the aim of overcoming and preventing injuries occurred during a medical treatment (Bogdan, 2011). The report and analysis of serious events is supposed to be a corner stone of this mechanism, so that any incident can be further analyzed and, if possible, prevented in future cases (although this purpose is more utopic than actually accomplished). On the other hand, this model is more committed in compensating the patient (nevertheless, the amount paid to the injured one is likely to be less than in the negligence model) than in finding someone to blame, since its basic assumption is that the origin of most damages lies in the system - in the hospital or even in the general health system -, not in the individual. Therefore, the patient will be compensated regardless of whether or not a fault was committed, whose existence is not even ascertained in the majority of cases.

2.1. The common notes

Based on these main principles we can pinpoint some identifying characteristics of this model, common to several legal orders.

Firstly, the fact that the injured patient is not required demonstrating the traditional requisites of juridical liability (except for causation). The patient is expected to establish some other requisites, whose prove is (at least theoretically) easier than the requisites of juridical liability.

Secondly, and connected with the previous feature, the division between compensation

and punishment. In other words, the entities that analyze the compensation claims presented by patients do not deal with disciplinary matters, nor the information they collect is communicated to the disciplinary bodies, so, there is an absolute firewall between the compensation process and the sanctionary process. This note raises some concerning issues regarding the accountability of the health care provider, even because punitive measures end up being very rare.

Another characterizing feature of the no-fault system is the limited roll of compensable injuries, a restriction achieved by imposing some eligibility criteria. Therefore, not every single damage is compensable, but only the ones that meet those criteria. However, and despite these limitations and exclusions, still the range of damages eligible for compensation remains broader than the compensable injuries in the negligence model.In spite of the exclusion of the traditional liability requirements, there is one that still persists in all no-fault schemes: causation. Therefore, the patient still has to demonstrate the causal link between the doctor's conduct and the damage, which is probably the main difficulty to obtain compensation in the no-fault model and, indeed, its demonstration can become an insurmountable difficulty (Bush et al., 1975). According to some studies, roughly 60% of all no-faults claims presented are unsuccessful, mostly due to the difficulty in proving causation (Bogdan, 2011).

2.2. The diverging notes

In spite of these common notes, the implementation of the no-fault model can assume many different features, as it is demonstrated by the huge differences that separate the model implemented in the Nordic countries from the one in place in New Zeeland, which are the two main existing no-fault models.

For example, the Nordic mechanism is covered by money raised through an insurance paid by health care providers (Kachalia et al., 2008; World Bank, 2004), while the New Zealand model is funded by taxpayers.

On the other hand, a brief overview on the different requisites demanded by these two concretizations of the no-fault model demonstrates that the specific criteria demanded for receiving compensation vary substantially. This is a decisive note, since the no-fault mechanism does not cover all the range of occurring injuries, but only the ones that fulfill a set of requirements, which vary according with the rules in place.

One of the requisites demanded by the Nordic model is the severity of the injury. For

instance, in Sweden it is imposed that the patient condition lasted for a minimum of 30 days, or that he was hospitalized for at least 10 days, that he suffers permanent disability or even death. In addition, the damage must have occurred during a medical treatment and because of it, therefore, this entire reasoning is focused on causation, essentially understood in similar terms to those governing tort law. Furthermore, the treatment in question must be provided by a licensed physician or under his responsibility, for the community only accepts the socialization of risk if the medical act enjoys public recognition in terms of professional competence. But the core requisite of the Nordic model is avoidability, i.e., it is required that the injury could have been avoided if the patient had been subjected to appropriate treatment (World Bank, 2004).

Differently, in New Zeeland rules the concept of “treatment injury”, which refers to the injury suffered by a person receiving a treatment from a licensed health professional, caused by that treatment (juridical causation), but not a necessary consequence of it. In contrast with the Nordic rules, the preventable nature of the injury (avoidability) is not required (Farrell et al., 2010). In sum, one of the most relevant differences between these two main models concerns the definition of “compensable injury”. In the Nordic case the concept of "avoidability" defines the range of compensable damages, turning it into a basic element of the whole compensatory structure; whereas the New-Zealander solution disregards the avoidable nature of the injury and, instead, revolves around the definition of “treatment injury”.

Another difference concerns the possibility to have the question decided by a court of law. In the majority of the Nordic countries the injured patient is allowed to present his case in front of a judge, but this path is rarely used as a first option whenever the injury is covered by the compensation fund[2]. The reason is that the compensation procedure of the no-fault scheme is simpler and more expedite because the patient is not required to prove all the demanding liability requirements of tort law (except for causation, a requisite that still persists in the no-fault model). The exception in this regard is Denmark, where the patient cannot resort to court whenever the damage in question is covered by no-fault scheme.

In contrast with the Nordics (apart the just mentioned Danish solution), in New Zeeland the patient is not allowed to use the court whenever the injury is covered by the no-fault scheme, even if the patient decides not to submit an application to the no-fault fund. Since the choice of the mechanism to react is not the result of the patient’s voluntary decision, it raises some

constitutional problems regarding the right to access to court. However, and despite the potential violation of a constitutional right, it is commonly understood that this solution results from a kind of social contract, which has even been endorsed by New-Zealanders courts. In sum, whenever the injury belongs to the list of damages covered by the no-fault model, the only available possibility to make use of legal remedies relates to punitive damages (whenever they are accepted) or moral damages (Farrell et al., 2010; OECD, 2006). But, in actual fact, rarely patients have an interest in accessing judicial courts, given their cost and slowness, in contrast with the substantially less expensive and quite rapid nature of the no-fault procedure.

3. The Nuclear Concept of Avoidability

3.1. Definition of the avoidable injury

Although the concept of avoidability is not a necessary note of the no-fault system, it undeniably became a crucial characteristic of it, namely due to the preponderance that it has assumed in the Nordic legal orders. This circumstance, allied to the fact that many advocate the substitution of the negligence criterion by the avoidability criterion as the corner stone of the entire structure of medical liability and patient compensation, justifies its special consideration in the present study. Avoidability is a concept coined by the Nordics especially for the no-fault model. It aims to express the idea that only preventable injuries will be compensated, thus, demystifying the traditional belief that the no-fault model compensates every single damage (Kachaliaet al., 2008; OECD, 2006). In the Nordic model patient's compensation depends on the following assessment: would the damage have happened if another type of medical act had been provided?

Differently, the classical model do deal with injuries suffered by patients during a medical act revolved around the concept of "medical fault", as something different from the adverse event and from the medical error, since none of these two figures imply the agent's culpability (Mello et al., 2006). The difference between the two of them is that the adverse event is something that occurs even when the best medical practices are respected, for reasons related with the limits still imposed to medicine; while in the medical error the agent has indeed committed some mistake, nonetheless, in juridical terms it is not possible to assign him any form of culpability. Therefore, neither the adverse event not the medical error implies juridical

liability. Conversely, the medical fault involves culpability and, if the remaining requisites of juridical liability (wrongfulness et al.,) are fulfilled, the agent will be convicted and the plaintiff will receive compensation (Raposo, 2013).

3.2. Avoidability v. Negligence

The designation of the model as “no-fault” can be misleading, because it creates the idea that this model totally disregards any consideration related with culpability. In fact, it is not so. Firstly, because it does not annihilate criminal responsibility, which inevitably remains for criminal offenses Secondly, because some medical damages are excluded from the non-fault system, therefore, in order to be compensated for those damages the injured patient must apply to tort law rules, which usually demand the agent’s culpability (except for the limited cases of strict liability, rarely applied to medical practice). Finally – this being the most interesting note – because even within the no-fault system, which supposedly takes no consideration of the agent’s culpability, the fact is that the idea of fault and culpability persists, though disguised of “avoidability”. In fact, some authors argue that, actually, the “avoidability” concept is not that different from the one of “culpability”, because if the damage could have been avoided this means that the health care provider has not delivered proper medical care, i.e., he was negligent (Maccourt & Bernstein, 2009; Mehlman & Nance, 2007).However, in order to assess the connection between “avoidability” and “negligence” it is imperative to clarify the definition of "proper medical care" for this purpose: does it mean any medical care considered adequate in the particular case or, in a more demanding way, does it refer to the best possible medical care? In the first hypothesis there will be, indeed, an overlap between “avoidability” and “negligence”, while in the second hypothesis this won’t be the case, since according with tort law the health care provider is not required to deliver the best possible treatment but merely a treatment considered suited to the case.

In fact, tort law prescriptions do not demand their recipients to act as super-humans, with the maximum of diligence, braveness and smartness, but merely as a standard man, with the common level of diligence, braveness and smartness, i.e., what the roman law called the “*bonus pater familiae*”. Likewise, in the particular case of medical practice tort law does not expect the doctor to be a kind of super doctor, but simply the standard doctor, therefore, providing the standard treatment (Raposo, 2013). Therefore, when the doctor’s conduct does not reach the

level of the "standard doctor" the patient will be compensated; in contrast, the patient will not receive any compensation if the treatment provided is considered adequate in light of the "standard doctor" criterion, even though it was not the best possible treatment.

If the "avoidable injury"– the one that deserves compensation according with the Nordic no-fault model – is defined as the one that could have been prevented by a different treatment (i.e., any other treatment could have prevented it, therefore, it is not required that the damage could only have been prevented by the best possible treatment) the reasoning underneath it becomes very similar to the one of tort law. This is the reason why, in our opinion, the formula that should be used in order to define the "avoidable injury" must be the injury avoidable by the best medical care. In other words, the no-fault compensation should be granted whenever the injury could have been prevent, even if only by the best possible treatment provided according to the highest existing medical standards. We are not sustaining that this should be the standard of conduct to assess the physician's behavior in a malpractice lawsuit. Instead, what we are saying is that only when the "avoidable injury" is defined as such it becomes possible to differentiate the avoidability criterion from the negligence criterion and, consequently, to distinguish the no-fault model from the negligence model. Otherwise both systems would operate in the same way, according with the same criteria, with the only difference that in the no-fault model compensation is paid by a found of risk socialization, whereas in the negligence model compensation would be paid by the health care provider (actually, by the insurance company, as it happens most of the times).

4. Negligence Model V. No-Fault Model

4.1. Fragilities and virtues of the no fault model

The benefits of no-fault model apparently seek to respond too many of the deficiencies of the negligence model (Bismarck & Paterson, 2006; Farrell et al., 2010; OECD, 2006).

It is a faster, less costly and less confrontational mechanism to solve disputes, thus, allowing the victim (actually, more victims, since its scope of application is wider) to have faster access to medical care.

For the health care professional the main advantage is that it alleviates the pressure on him. Indeed, the doctor does not feel as a target for obtaining money, since the amount granted

as compensation is limited. Actually, the procedure for patient compensation is conceived as a mere mechanism for paying patient's expenses and not as a kind of punishment, as it happens in a lawsuit. In addition, the value to be paid is covered by the risk fund, not by the health practitioner. These notes substantially alleviate the pressure over doctors, either the juridical pressure (the anxiety of being sued and the negative outcomes of a lawsuit), either the financial pressure (the risk of paying huge amounts in compensations or, at least, of having the insurance company paying those amounts and, consequently, suffer a drastic increase in the premiums paid). For all these reasons defensive medicine is not as common as in the negligence model.

Furthermore, because doctors are not so afraid of being sued, their relationship with the involving stakeholders – patients, patients' relatives, other doctors, the institution and the legal team defending them - becomes more transparent. Consequently, it is assumed that within the no-fault model the notification of adverse incidents is more frequent – though this apparent truth does not correspond to reality -, which seems to increase the possibility of learning from their mistakes and, concomitantly, preventing them in the future.

However, and in spite of the apparent success of the no-fault model, prudence is recommended regarding more enthusiastic impulses, as this model also presents some weaknesses (Eyben, 2001; Farrell et al., 2010; Maccourt & Bernstein, 2009; OECD, 2006).

One of its problems relates with the sum granted as compensation, frequently beyond the amount needed to cover the entire set of damages suffered by the patient, especially regarding moral damages, which are often directly excluded. But even regarding patrimonial damages the amount paid may be insufficient, since frequently compensations are submitted to legally imposed thresholds. In addition, some injuries are not covered, as it happens with the ones that do not satisfy the definition of "avoidable injury" imposed by the Nordic solution, or the definition of "treatment injury" in the New Zealander legal order.

It can also be argued that in terms of patient safety this model is not as striking as it apparently seems, a conclusion that can be deduce from the - far from impressive - percentages of error reporting, actually very close from the percentages typical of negligence models (Schwartz, 2013). Even when errors are reported, the fact is that they are not necessarily analyzed, thus, jeopardizing the benefits of error reporting.

Nor should we take for granted the improvement in doctor-patient relationship, allegedly

resulting from the no-fault model, as the existence of excuses or explanations is not necessarily a requirement of the no-fault system. Although the doctor is not so fearful of reprisals, error disclosure is not a part of the "medical culture" and it is required much more than mere legal impositions in order to change the medical attitude.

On the other hand, the disappearance of the litigation threat may discourage safer practices within the no-fault model, since actually the health care professional is hardly ever penalized. It is a fact that some people do not require the threat of a hypothetical sanction in order to adjust their behavior; nonetheless, most of us do need the carrot and the stick. So, in the absence of any penalty, chances are that the health care provider will not conform his conduct to the best medical practices, thus, endangering patient safety.

Furthermore, it has been pointed out that one of the virtues of the no-fault model is the rapid, costly and easy nature of the procedure to obtain compensation; but the fact is this very same characteristic may increase unfounded complaints, fuelled by the apparent ease of the procedure.

In addition, the costs saving for the State can be more deceptive than real. Firstly, because in some communities all the injured patients, even the ones with minor injuries, will resort to the risk socialization fund – since it is cost free and very easy to activate -, which will raise the monetary amount necessary to maintain the fund and, consequently, the economic pressure on the State. Secondly, because the no-fault model actually requires the maintenance of two reaction apparatus, each one with its own costs: administrative organs to deal with no-fault complains, but also judicial organs, still required to deal with the damages not covered by the no-fault model, or as an alternative reaction pathway and also for criminal proceedings.

A possible violation regarding the fundamental right of accessing to the court has also raised problems, since some legal orders require the mandatory use of the no-fault procedure, without allowing the claimants to make a free choice regarding the preferred mechanism of reaction.

4.2. Fragilities and Virtues of the Negligence Model

One of the most pertinent critics (Kachaliaet al., 2008; OECD, 2006) to the negligence model relates with its inherent adversarialism, i.e., the fact that it promotes the open conflict between patient and doctor, disrupting the confidence that should necessarily exist between them

and basically ruining the patient's chances of receiving further health care from that provider, an especially pressing problem for patients who need continuous treatment.The conflict, in turn, gives rise to an excessive consumption of time (the formal procedure inherent to a lawsuit, especially facts finding, is time consuming) and money (both from the injured and from the State itself, mainly due to attorneys' fees and administrative costs), precisely because of the way - also confrontational – of solving the dispute.

An aspect to have in consideration is the negative effect that litigation has on the health care professional; including in his career and personal live, such as the loss of reputation, social disregard and shame (Ong & Kachalia, 2013).

Another of its weaknesses is related to the harmful consequences of excessive punishment, there is, overdeterrence, a common effect of the negligence model. On the one hand, the fear of prosecution and of an eventual conviction is pushing doctors to defensive medicine and leaving some medical specialties (obstetrics, gynecology, surgery) with no professionals (OECD, 2006). On the other hand, the atmosphere of fear and secrecy leads health care professionals to hide relevant information from their patients, from the hospital, from colleagues and even from the legal team supporting them, eventually ruining their defense in court. But the most dramatic effect of the omission of information is that it prevents the study of many of the errors committed - errors that, if further analyzed, could be prevented in the future - therefore, jeopardizing patient's safety. This clime of silence also inhibits explanations and apologies, once again contributing to ruin doctor-patient relationship. Actually, many patients feel encouraged to take the incident to court precisely because they don't receive a proper explanation from their doctor, a simple gesture that in many situations could avoid litigation.

The randomness of the judicial proceeding is also target of criticism. Lawsuits are perceived as a kind of Russian roulette: they grant compensations, and sometimes excessive ones, to plaintiffs that do not deserve them, by contrast, it leaves with empty hands those who were truly victims of negligent acts. This disparity of criteria, an the consequent uncertainty about the outcome of a lawsuit, proved to be equally harmful to patients and to health care professionals: the former because of the great injustices that the system causes, leaving unprotected those who are most in need; the latter because the compensation criteria are so blurred that doctors are never sure of what behavior is expected from them and how they should

perform in order to avoid condemnation.

Despite being under fire, the fact is that the negligence model still maintains some merits (OECD, 2006). A valuable note of the negligence model is its flexibility in the award of damages, a characteristic lacking to the no-fault model, whose compensations are more standardized. In effect, the negligence model has a more flexible approach to the determination of compensation, covering different types of damages, such as moral and patrimonial damages, and even punitive damages in the legal orders in which those ones are allowed. On the other hand, the negligence rule presents an important deterrence effect. Indeed, by imposing to health care providers the burden of paying the compensation, the negligence model encourages them to act in order to avoid that "punishment" in future cases. Consequently, it provides an alternative to the lack of accountability characteristic of the no-fault model.

5. Final Conclusions: Is the No-Fault Model Appropriate to Asian Countries?

In spite of the (apparent) increased value of the no-fault model, it also presents several serious failures. But even if its advantages surpassed the ones of the negligence model, the fact is that the no-fault system cannot be transposed to every legal order. Quite the opposite, its implementation can be a challenge, since it requires very demanding requisites to operate (Bismark & Paterson, 2006): on the one hand, a strong social security system to "feed" all the complaints that are expected under this system; on the other hand, a hardly litigant community, in order to reduce the number of complains; finally, a medical community able to comply with the best medical practices even without the threat of a sanction. In the absence of those requisites chances are that the social fund that pays compensations will enter in collapse because of the high number of complains and the lack of a social security structure able to help funding all the compensations expected. Furthermore, without proper sanctions, doctors may relax and disregard the due standard of care. The mentioned requisites hardly exist in Asia (actually, they hardly exist around the world, except for very specific communities), therefore, the no-fault model is not the most adequate solution for Asian countries deal with medical malpractice and patient's compensation.

However, this conclusion does not preclude the use of the no-fault model for restrict scenarios (as it happens in the north-American states of Florida and Virginia regarding

neurological injuries in newborns), namely those cases in which it is very difficult for the plaintiff to demonstrate in court the requisites of juridical liability; but, on the other hand, the damage suffered is particularly severe, thus, it demands an effective compensation and it cannot rely on the vicissitudes of tort law proceedings. In addition, the fragilities pointed out to the no-fault model should not prevent the transposition of some of its main features to the negligence model, such as the implementation of health courts.

In sum, the negligence model should be maintained as the main model to deal with medical malpractice and patient's compensation in Asia, but subject to the referred improvements, in order to achieve some goals traditionally overlooked by this model, such as patient's safety and the improvement of doctor-patient relationship.

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